Medway Hospitals ®
The way to better health

MH/ PRINT / 0075 / MRD

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	✓	
- Name, Age & Sex of Patient	✓	
- General Admission Consent	✓	
- Initial Assessment of Patient / Diagnosis	✓	
- Nutritional Assessment by Consultant	✓	
- Plan of care counter signed by the Consultant	✓	
- Treatment Orders - Date, Time, Name & Sign.	✓	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	✓	
- Vital Signs Chart (TPR Chart)	✓	
- Intake Output Chart	✓	
- Drug Chart (Duly filled)	✓	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist		
- Anesthesia Assessment Sheet		
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon		
- Surgery Notes - Post Operative Plan		
- Pain Scoring System		
- Blood Transfusion if done		
- High Risk Procedures		
- A copy of the Discharge Summary	✓	

169 61.65

ESI

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IPD/2022/002

Medway Hospitals®
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(A Unit of United Alliance Healthcare Pvt Ltd)

ADMISSION SLIP

Medway Heart Institute
Where heart beat never stops...

Admitting Doctor: Dr. Gnanavelu. **Speciality:** Cardiologist

Advised Date & Time: 2/1/24 @ 11.20 Am

Provisional Diagnosis:

CAD. Awmi - Lysed @ STK 1/2/2023 / Moderate LV dysfunction

Reason for Admission: ☐ Medical Management ☐ Surgical Management

☐ Others (please specify details) PTCA.

Admission Type: ☐ Day Care ☐ ER ☐ Ward

☐ ICU _____ (Specify details)

Surgery / Procedure Name (if planned):

PTCA.

Blood Product Requirement: ☐ No ☐ Yes *(Kindly specify details of components required in space below)*

Expected Duration of Stay: Day Care

Expected Cost of Treatment *(as per Financial Counseling Form)*:

Payer: ☐ Self ☐ Insurance ☑ Others: GSI ESI

Instructions to Nurse (if any):

-> Admission in ward

-> To collect the RBS / creatinine / BHb report.

Any other Instructions (if any):

GSI

Doctor's Signature	Name	Reg. No.	Date	Time
	Dr. Gnanavelu	39469	2/1/24	11.20 Am

For admission desk staff only:

Room Category:

- ☐ General Ward
- ☑ Single Room
- ☐ Twin Sharing
- ☐ Deluxe Room
- ☐ Suite Room
- ☐ Others _____

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
02/01/2024	11.28 PM	02/01/2024	11.28PM

Source:

- ☐ OPD
- ☐ ER
- ☑ Direct

To be filled only if Blood requirement specified by the Doctor:

Is Blood Reservation and Blood Bank clearance completed as advised: ☐ Yes ☒ No

Front office Staff Signature	Name	Emp. No.	Date	Time
	S.Vignesh	0262	02/01/24	11.28

ESI

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/HOSP/2022/129

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Medway Heart Institute
Where heart beat never stops...

ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	Mr. Gopinath 28c Govindaswamy St Nanganallur Ch-114	9380597138 7358293926
Occupation G/w		

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
ESIC	02/01/24 11:28 Am	4/1/24	3 days

UNIT: cardiology | MLC ☐ Yes ☑ No If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
CAD - RECENT AWMI - LYSED WITH STK (12/2023)	I25.2
CAD - SIGNIFICANT LAD & DIAGONAL BIFURCATION	I25.1
DISEASE - 20.12.2023	
MILD LV DYSFUNCTION EF - 46%	I50.1

DATE	OPERATION / PROCEDURES	ICPM Code
2.1.24	IVUS GUIDED PTCA TO LAD.	00.66

DATE	TYPE OF ANESTHESIA				
2.1.24	☐ GENERAL	☐ SPINAL	☑ LOCAL	☐ REGIONAL	☐ EPIDURAL

DISCHARGE STATUS

☑ Cured	☐ Discharge at Request	☐ Expired < 48 hours
☐ Improved	☐ Against Medical Advice	☐ Expired > 48 hours
☐ Unchanged	☐ Absconded	☐ Post-Operative Death
	☐ Transferred to	

39469
Signature of the Consultant

Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient...R. Gopinath... who is my ....husband..... (Relationship).

I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.

However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.

I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

I have read out and explained the contents of the above to the Signatory in his vernacular .

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி .....
.....க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கிறேன்.

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date 2.1.2024	Signature of the Patient / Relative / Gurdian

உறவுமுறை

Nature of Relationship

ISE

Medway Hospitals®
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IP/2022/008

Medway Heart Institute
Every heart beat counts

GENERAL CONSENT FOR ADMISSION

I, R. Gopinath the ☑ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

☐ Been explained this consent form in English, which I fully understand.

- I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
- I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
- I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
- I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
- I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities.
- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.

- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient	R. Gopi	R. Gopinath	02/1/24	11.28 AM
Surrogate/Guardian (if applicable #)	G. Selvi	G. Selvi *(Write name and relationship with patient)*	02/1/24	11.28 AM
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	G. Veera Raghavan		02/1/24	11.28 AM
Interpreter (if applicable)				

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

DISCHARGE SUMMARY

IP No.	IPH2024000011	**D.O.A**	: 02/01/2024
UHID	MHI202381395	**D.O.P**	: 02/01/2024
Name	Mr. GOPINATH. R	**Room No.**	: 110
Age / Gender	48Years / MALE		
Consultant	: **Dr. G. Gnanavelu.** MD., DM., (cardio) FACC Chief Cardiologist	**D.O.D**	: 04/01/2024

DIAGNOSIS:

CAD – RECENT AWMI - LYSED WITH STK (12/2023)
CAG – SIGNIFICANT LAD & DIAGONAL 1 BIFURCATION DISEASE - 20.12.2023
MILD LV DYSFUNCTION EF – 46%.

PROCEDURE:

SUCCESSFUL IVUS GUIDED PTCA + STENT TO LAD DONE USING 2.5 X26 MM ONYX TRUCOR DES & DIAGONAL USING 2.25 X18MM ONYX TRUCOR DES WITH MINICRUSH TECHNIQUE DONE ON 02.01.2024.

BRIEF HISTORY:

Mr. Gopinath. R, 48years old male, presented with complaints of central chest pain associated with sweating (+). He was evaluated in ESIC hospital and advised Coronary angiogram which revealed **SIGNIFICANT LAD & DIAGONAL 1 BIFURCATION DISEASE done on 20.12.2023.** He was further advised for **IVUS guided PTCA to LAD-diagonal(2 stents)** for which he has been admitted.

No H/O fever, vomiting, diarrhea.

N/K/C/O Type II Diabetes mellitus , systemic hypertension, Dyslipidemia, CVA and hypothyroidism.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

P I C C L E	-	NIL
HR	-	55bpm
BP	-	110/70 mmHg
SPO_2	-	96% in room air
CVS	-	S1S2 (+)
RS	-	BAE (+)
Abdomen	-	Soft
CNS	-	NFND

INVESTIGATIONS :

BLOOD: Hb- 14.5gm/dl, TWBC – 11760cells /cumm, PLT – 213000cells/cumm, Urea – 18mg/dl, Creatinine – 0.7mg/dl, Sodium – 136mg/dl, Potassium – 4.2 mg/dl, Trop I – 23.4, INR – 1.0.

ECG: sinus rhythm, HR – 63bpm, ST elevation in I, aVL,V2-V6 leads.

ECHO: RWMA (+) Mid septal, mid anteroseptal hypokinesia. Distal septal, distal lateral apical hypokinesia. Dilated LA, LV. Moderate LV dysfunction EF – 38%. ¼ MR. No PHT / clot/ PE.

POST PCI INVESTIGATIONS:

BLOOD(03.01.2023) :

Test Name	Result	Reference Value	Units
UREA	17	14 - 40	mg/dl
CREATININE	0.76	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mg/dl

ECG : sinus bradycardia, HR – 50bpm, evolved AWMI changes.

SCREENING ECHO(03.01.2024) : S/P PTCA. All chambers normal sized. RWMA (+) – All apical segments, apex, mid anterior hypokinetic. Mild LV systolic dysfunction. EF – 46%. Normal RV systolic function. All valves structurally normal. IAS / IVS intact. Trivial MR. Trivial TR. Mild PAH. IVC normal in size and collapsing. No clot / vegetation / effusion.

COURSE IN THE HOSPITAL:

Mr. Gopinath. R, 48years old male, admitted with above mentioned complaints. Basic investigation was done. After obtaining consent, he underwent ***SUCCESSFUL IVUS GUIDED PTCA + STENT TO LAD DONE USING 2.5 X26 MM ONYX TRUCOR DES & DIAGONAL USING 2.25 X18MM ONYX TRUCOR DES WITH MINICRUSH TECHNIQUE DONE ON 02.01.2024*** by Right radial artery approach. Post procedure was uneventful and shifted to CCU. Post procedure ECG shown no fresh ischemic changes. He was treated with dual anti-platelets, statin and other supportive measures. His general condition improved. He got shifted to ward, RFT within normal limits, maintained adequate fluid balance. His medications are optimized and he is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile
General condition Stable

GCS	-	15/15			
Temp	-	98.6°F	BP	-	110/70mmHg
PR	-	80/min	SPO2	-	95% in room air

ADVICE MEDICATIONS:

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	**TAB. ECOSPRIN** (ASPIRIN)	**75 MG**	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2.	**TAB. AXCER** (TICAGRELOR)	**90 MG**	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	**TAB. ATORVA** (ATORVASTATIN)	**40 MG**	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	**TAB. MET XL** (METOPROLOL)	**25 MG**	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5.	**TAB. FLAVEDON MR** (TRIMETAZIDINE)	**35 MG**	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	**TAB. NITROCONTIN** (NITROGLYCERIN)	**2.6 MG**	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	**TAB. PAN** (PANTOPRAZOLE)	**40 MG**	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
8.	**TAB. ALPRAX** (ALPRAZOLAM)	**0.5 MG**	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
9.	**TAB. ISDN**	**5 MG**	0	0	0	S/L	SOS (IF CHESTPAIN)	

DISCHARGE ADVICE	
DIET	LOW FAT & DIABETIC DIET.
PHYSICAL ACTIVITIES	AS TOLERATED & AVOID STRENUOUS ACTIVITIES
REVIEW	REVIEW WITH **DR. GNANAVELU AFTER 1 WEEK WITH RFT & ECG REPORTS.**

To report: If temp > 101 'F / Difficulty in breathing / chest pain / Giddiness/ palpitations.
Any other significant symptoms. In case of emergency Contact: Medway Hospitals @ 4310 8959.

CONSULTANT SIGNATURE

Dr. G. Gnanavelu. MD., DM., (cardio) FACC
Chief Cardiologist

Typed by: Ezhilarasi.

Dr. G. Gnanavelu MD. DM (cardio), FACC
Chief Cardiologist
Reg. No: 39469

"I understood the Content of the discharge summary."

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(A Unit of United Alliance Healthcare Pvt Ltd)

NABH

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IP/2022/107

Medway Heart Institute
Every heart beat counts

INPATIENT INITIAL ASSESSMENT

Date: 2/1/23 **Time of arrival in ward:** 12.00

Allergies *(if Yes, specify details)*:

Drugs ☐ Yes ☑ No

Blood Transfusion ☐ Yes ☑ No

Food ☐ Yes ☑ No

Others

Vital Signs: Temp: 98.6(°F) | Pulse / HR: 55 (beats/min) | BP: 110/70 (mmHg)
Respiration: 20 (breaths/min) | SpO_2: 96 (%) | Height: 168(cms) | Weight: 61.6 (kgs) | BMI: 21.8kg/m²

Pain: ☑ Yes ☐ No. If Yes, Score: 1/10
Pain Scale Used: ☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)
Duration: Location: chest
Pain Character: ☑ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

CHIEF COMPLAINTS & HISTORY OF PRESENTILLNESS

Pt. presented to OPD c complaints of chest pain x dull in character x 1 month.
Then pt. had coronary Angiogram on 20/12/23 showing Significant LAD & Diagonal bifurcation lesions

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☐ Yes ☑ No. If Yes, duration: – Hypertension: ☐ Yes ☑ No. If Yes, duration: –

Others: N/K/C/O CKD/ BA/Thyroid..

Past Surgical History:

Nil.

Present Medication *(for Medication Reconciliation)*:

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	TAB. ASA	150mg	oral	0-1-0	1/1/24.	☐ Yes ☐ No
2.	TAB. ACER.	90mg	oral.	1-0-1.	2/1/24	☐ Yes ☐ No
3.	TAB. ATORVA	40mg	oral	0-0-1	1/1/24	☐ Yes ☐ No
4.	TAB. MET XL	25mg	oral	1-0-1	2/1/24	☐ Yes ☐ No
5.	TAB. ENVAS	2.5mg	oral	1-0-1	2/1/24	☐ Yes ☐ No
6.	TAB. FLAVEDON MR	35mg	oral	1-0-1	2/1/24	☐ Yes ☐ No
7.	TAB. NITRO CONTIN	2.6mg.	oral	1-0-1	2/1/24	☐ Yes ☐ No
8.	TAB. PAN	40mg	oral	1-0-1	2/1/24	☐ Yes ☐ No
9.	TAB. ALPRAX	0.5mg	oral	0-0-1	1/1/24	☐ Yes ☐ No
10.	TAB. ISDN	5mg.	S/L	Oral.	-	☐ Yes ☐ No

Family History:

—

Personal / Social History *(Tick whichever is applicable)*

Lifestyle: ☐ Sedentary ☑ Active **Occupation:** _____

Smoking: ☑ Yes ☐ No **Alcohol:** ☐ Yes ☑ No **Recreational Drug Use:** ☐ Yes ☐ No

Others: ~20 years ; Stopped 2 weeks back

Menstrual and Obstetric History *(to be filled up for female patients)*:

—

General Physical Examination:

Pallor: ☐ Yes ☑ No **Icterus:** ☐ Yes ☑ No **Clubbing:** ☐ Yes ☑ No

Edema: ☐ Yes ☑ No **Lymphadenopathy:** ☐ Yes ☑ No

SYSTEMIC EXAMINATION

CVS: $S_1 S_2$ (P)

Respiratory System: BAE (P), NAD

Gastrointestinal System: Soft, NTND

Central Nervous System: NFND, Able to move all (4) limbs

Urinary / Reproductive / Locomotor System: —

Skin / Opthalmic / ENT

Suspected of contagious disease: ☐ Yes ☒ No Immuno compromised status: ☐ Yes ☒ No

Isolation required: ☐ Yes ☒ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:

☒ Normal ☐ Anxious ☐ Depressed ☐ Others: _____

Nutritional Screening *(ESPEN Guidelines for Nutritional Screening - NRS 2002)*:

Weight loss within the last 3 months? ☐ Yes ☒ No Is the patient severely ill? *(e.g. in Intensive Therapy)* ☐ Yes ☒ No

Reduced dietary intake in the last week? ☐ Yes ☒ No Is the BMI < 20.5? ☐ Yes ☒ No

Interpretation: **Yes:** If the answer is "YES" to any 2 questions, the patient is at nutritional risk
No: If the answer is "NO" to all questions, the patient is at Normal and not at risk

Provisional Diagnosis:

- CAD - AWMI - lysed with STK (12/23)
- Moderate LV dysfunction.
- EF - 38% by bi plane method & EF - 40% by visual method. (16/12/23)

Plan of Care:

- PTCA to LAD - Diagonal bifurcation

IVUS guidance.

- NPO from 9 am
- Procedure at 1 Pm.

15/12/23

Investigations Advised:

ECG, Hb, Sr. Creatinine, RBS, ESR by echo.

HIV
HBsAg
VDRL
Anti HCV
} NR.

INR - 1.0

Y.C - 11760

Hb - 14.5

Urine routine - (N).

Diet Advice:

☑ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet

☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet

☐ Neutropenic liquid diet ☐ Others: _____

Early Discharge Planning *(fill in those which are appropriate at this stage)*: *PFE: Patient Family Education*

Special support needed at home	☐ Yes ☑ No	If Yes, PFE done
Home equipment anticipated	☐ Yes ☑ No	If Yes, PFE done and equipment advised
Physiotherapy at home anticipated	☐ Yes ☑ No	If Yes, educated on physical limitations, if any
Wound care needs anticipated at home	☐ Yes ☑ No	If Yes, educated on signs on infection
Pain Management	☑ Yes ☐ No	If Yes, PFE done and medication advised
Special Dietary needs	☑ Yes ☐ No	If Yes, educated on dietary restrictions, food drug interactions and allergies
Continuous / ongoing care anticipated	☑ Yes ☐ No	If Yes, educated on various aspects of ongoing care required
Other special education need, i.e.:	☑ Yes ☐ No	If Yes, PFE done
Nature of post hospital needs like patient safety, infection control, fall risk, etc, addressed	☑ Yes ☐ No	If Yes, specific education given

Others:

	Signature	Name	Reg. No.	Date	Time
Resident Doctor	183573	Dr. Sujith. R	183573	2/1/24	12:20 Pm.
Consultant		Dr. Gnanavelu	39469	3/1/24	9:30
Patient Attendant		Relationship Wife		2/1/24	12:00 Pm

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MHI/IP/2022/041

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

DOCTOR'S PROGRESS NOTES

DATE	NOTES
2/1/24	Rvvs guided PTCA to LAD & Major diagonal
2pm	(Bifurcation PTCA)
	- Access
	- Rt radial access
	- 6F sheath
	Medtronic Onyx TruCor™ RX DES 2.25 mm x 18 mm REF TRCR22518X LOT 0011791142 2026-05-22
	Medtronic Onyx TruCor™ RX DES 2.5 mm x 26 mm REF TRCR25026X LOT 0011945783 2026-09-07
	Procedure:
	- ↓ LA c SAP, Rt radial access obtained & 6F sheath placed.
	- By using 6F EBU 3.0 guide, LCA engaged & CAG obtained
	significant Mid LAD & major diagonal bifurcation disease.
	- LAD & diagonal lesions crossed c BMW guidewires
	- Diagonal lesion predilated c 2×12mm Mozec balloon upto 12 atm for 10sec
	- Diagonal stented c 2.25×18mm Onyx TruCor DES at 12 atm for 10sec
	- LAD lesion predilated c 2×12mm Mozec balloon upto 12 atm for 10sec & 2.75×8mm Mozec balloon upto 18 atm for 10 sec
	- LAD stented c 2.5×26mm Onyx TruCor DES at 12 atm for 10sec
	- Stent post dilated c 2.75×8mm Mozec NC balloon upto 18 atm for 10sec & Mozec NC 3×8mm balloon upto 16 atm for 10 sec
	- Kissing balloon inflation c 2.75×8mm Mozec NC balloon in LAD & 2×10mm Apollo NC balloon in D1 upto 14 atm for 10 sec.
	- Kissing inflation c 3×8mm Mozec NC balloon in LAD & 2.5×10mm Across Hp NC balloon in D1 at 11 atm for 10 sec
	- Check CAG showed optimal deployed stents c TIMI III flow
	(PTO)

DATE	NOTES
	- IVUS study done in LAD
	- Good stent expansion & apposition
	- Proximal & distal edge (N)
	- MSA - 6.66 mm²
	- Pt Hemostasis achieved & sheath removed
	- Hemodynamically stable
	- Shifted to ICCU
	Adv
	- T. Ecospirin 75mg 0-1
	- Rpt urea/cr tomorrow morning - T. Axcer 90mg 1-
	- Screening echo tomorrow - T. Atorva 40mg 0-0
	- Others cont the same
2/1/21 6pm	[illegible]
	Procedure from cath lab
	O/E
	Conscious
	Oriented
	Mobility
	Adv
	Follow post cath orders

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH202400001
Dr.G. GNANAVELU

P/2022/041

Medway Heart Institute
beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
2/1/24	S/B Dr. Balaji
9 PM	pt. remd.
	drip will post PTCA.
	symptomly better.
	o/E - CL for Hybrid
	BP - 120/70 mm Hg
	HR - 56/min.
	CVS - S1 S2 (+)
	B - BAE (+)
	Adv
	Plan explained done

(50)

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(Affix Label here)
Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/ICU/2022/036

Medway Heart Institute
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CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mr. Gopinath the ☑ Patient or ☐ Representative of patient have *(please tick the correct option above and below):*

☑ Read

☑ I have been explained in detail by the treating doctor and I understand about the condition of me / and my patient or my patient's illness and I am aware of the all the possible outcomes.

☑ Been explained this consent form in English / Tamil, which I fully understand and understood the information provided about **ICU Treatment**

I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedures needed to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedures like Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and further methods of monitoring which are needed to improve or treat my condition.

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:
A Central venous catheter or central line is a long, soft, thin, hollow tube placed into a large vein (blood vessel). Compared to a peripheral line, central line is larger, longer and is placed into a large vein in the neck, upper chest or groin.

Intended benefits:
Common reasons for having a central line include:

- To give IV medications over a long period of time because a large vein can tolerate an IV catheter for a longer time than a small vein. Examples of such medications are antibiotics and chemotherapy.
- To rapidly deliver large amounts of fluid or blood, for example when a person is in shock.
- To give multiple drug infusions in critically ill patients
- To directly measure blood pressure in a large or central vein. This can help determine how much fluid a person needs.
- For patients who require frequent blood draws to be sent to the laboratory, the central line allows for blood to be drawn without repeatedly pricking the patient.
- To deliver nutrition directly into the blood when food or liquids cannot be given through the mouth, stomach, or intestine.
- To give vasopressors (Blood pressure increasing drugs) for a patient in shock, as giving vasopressors through peripheral line can cause injury to the small blood vessels.
- In some cases, two of the lumens on the central line can be used to perform dialysis, with one lumen used to take blood out of the vascular system and another lumen used to return the dialyzed blood to the body.

Possible risks and complications:

- Discomfort during placement: Discomfort can result from the needle stick and placement of the catheter at the time it is inserted.
- Bleeding: Bleeding can occur at the time the catheter is inserted. The bleeding is usually mild and stops by itself
- Infection: Any tube (catheter) entering the body can make it easier for bacteria from the skin to get into the bloodstream. Special care in cleaning and bandaging the skin at the catheter site can decrease the risk of infection.
- Thrombosis
- Arrythmia
- Pneumothorax (Collapsed lung): When a central venous catheter is placed in the chest area, if the needle passes through or misses the vein, the needle could pierce the lung causing the lung to collapse. If this happens, lung will be reflated by placing a tube between the ribs to remove the air that has leaked from the lung.

I have been explained the implications of not undergoing this procedure like:

- Worsening of clinical condition of the patient.
- Repeated pricking for blood samples.
- Difficulty in getting peripheral venous access.
- When high dose vasopressors are needed, ischemia to the distal part of the limb.

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:
Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.
The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

Intended benefits:
The procedure might be needed for you / your patient for any of the following reasons:
- to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
- when patient needs help to breathe
- when patient has a head injury and cannot breathe on his / her own
- when patient needs to be sedated for a period of time in order to recover from a serious injury or illness

Possible risks and complications:
- Injury to teeth or dental work
- Injury to the throat or trachea
- Bleeding
- Lung complications or injury
- Aspiration (stomach contents and acids that end up in the lungs)
- Other Risks (if any): _____

Possible alternatives:
Non invasive ventilation can be helpful in a few situations. But when Endotracheal Intubation is required, there can be no alternative treatment offered.

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful prosedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	G.Selvi	G.Selvi Wife *(Write name and relationship with patient)*	21/1/24	18:00
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	G.Selvi	G.Selvi wife	21/1/24	18:00
Interpreter (if applicable)				

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned procedure, to the patient / patient representative. I am confident that he / she has understood the information fully as described in this document.

	Signature	Name	Reg. No.	Date	Time
Doctor		Dr-Vel	9116 8	21/1/24	7pm

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Patient Details *(Affix Label here)*
Name:
UHID:
DOB: Sex:
DOA:
Consultant:

MHI/ICU/2022/036

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உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

_____ *என்ற பெயர் கொண்ட* □ *நோயாளியான அல்லது* □ *நோயாளியின் பிரதிநிதியான*
_____ நான், இந்த ஒத்திசைவு படிவத்தை (மேலே மற்றும் கீழே உள்ளவற்றில் சரியான விருப்பத்தேர்வை தயவுசெய்து டிக் செய்க)

□ வாசித்திருக்கிறேன்
□ சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு விளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.
□ நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

எனது அல்லது எனது நோயாளியின் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேவைப்படும் மருத்துவ சேவைகள் பற்றி மருத்துவரிடம் விவாதிக்க எனக்கு வாய்ப்பிருந்தது என்று நான் உறுதியளிக்கிறேன். எனது / எனது நோயாளியின் நோய்க்கு சிகிச்சையளிக்கவும் சுவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை சுவாச வழிமுறை, மத்திய சிரை அணுகுவசதி இதய தமனி தமனிக்குழல்கள் உட்பட மூச்சுப் பெருங்குழலுக்குள் குழாய் செருகுதல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செய்யவும் இதன்வழியாக நான் ஒப்புதல் அளிக்கிறேன். மேலும் எனது நிலைமைக்கு சிகிச்சையளிக்க அல்லது அதனை மேம்படுத்த தேவைப்படும் கண்காணிப்பு வழிமுறைகளை மேற்கொள்ளவும் ஒப்புதல் அளிக்கிறேன்.

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:
ஒரு மைய சிரை கதீட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:
மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

- ஒரு சிறிய நாளத்தைவிட, ஒரு பெரிய நாளமானது நீண்ட காலஅளவிற்கு ஒரு IV கதீட்டரை தாங்கும் என்பதால், நீண்ட காலஅளவிற்கு IV மருந்துகளை வழங்குவதற்காக. ஆன்ட்டிபயாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நபர் அதிர்ச்சியில் ஆழ்ந்திருக்கும்போது.
- உயிருக்கு ஆபத்தான நிலையிலுள்ள நோயாளிகளுக்கு ஒன்றுக்கு மேற்பட்ட பல மருந்து உட்செலுத்தல்களை வழங்குவதற்கு.
- ஒரு பெரிய அல்லது மைய சிரை / நாளத்தில் நேரடியாக இரத்தஅழுத்தத்தை அளவிடுவதற்கு. ஒரு நபருக்கு எந்தஅளவு திரவம் தேவைப்படுகிறது என்பதை தீர்மானிக்க இது உதவக்கூடும்.
- பரிசோதனையகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு ஊசிகுத்தி இரத்தம் எடுப்பதற்கு பதிலாக, எளிதாக இரத்தம் எடுக்க மைய லைன் வகை செய்கிறது.
- வாய், வயிறு அல்லது குடல் வழியாக தர இயலாதபோது ஊட்டச்சத்துகளை நேரடியாக இரத்தத்திற்குள் கலக்குமாறு வழங்குவதற்கு.
- புறவெளி லைன் வழியாக வாசோபிரெசர்ஸ் - ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேர்வுகளில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாசிஸ் செய்யப்பட்ட இரத்தத்தை உடலுக்கு திரும்ப அனுப்புவதற்கு மற்றொரு குழலையும் பயன்படுத்தலாம்.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பொருத்தப்படும்போது அசௌகரியம்: ஊசியால் குத்தும்போது மற்றும் கதீட்டரைப் பொருத்தும் நேரத்தில் அதனை உட்செலுத்துகின்ற நேரத்தில் அசௌகரியம் ஏற்படக்கூடும்.
- இரத்தக்கசிவு: கதீட்டர் உட்செலுத்தப்படும் நேரத்தில் இரத்தக்கசிவு நிகழக்கூடும். இந்த இரத்தக்கசிவு வழக்கமாக மிகச்சிறிய அளவில் லேசாக இருக்கும் மற்றும் அது தானாகவே நின்றுவிடும்.
- தொற்று: உடலுக்குள் நுழைக்கப்படும் எந்தவொரு குழாயும் (கதீட்டர்), சருமத்திலிருந்து பாக்டீரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதீட்டர் பொருத்தப்படும் இடத்தை தூய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉறைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுரையீரல் உறைக்காற்று நோய் (நுரையீரல் துவண்டு மடிதல்): மார்பு பகுதியில் ஒரு மைய சிரைகதீட்டர் பொருத்தப்படும்போது ஊசி சிரை / நாளத்தின் வழியாக கடந்து செல்லுமானால் அல்லது அதை தவறவிடுமானால் அந்த ஊசி நுரையீரலுக்குள் ஊடுருவி, நுரையீரல் துவண்டு மடிவதை விளைவிக்கும். இது நிகழுமானால், நுரையீரலிலிருந்து வெளியே கசிந்திருக்கின்ற காற்றை அகற்றுவதற்கு விலாக்களுக்கு இடையே ஒரு குழாயை வைப்பதன் மூலம் நுரையீரல் மீண்டும் மீட்பு வீக்கம் பெறுமாறு செய்யப்படும்.

இந்த மருத்துவ செயல்முறையை மேற்கொள்ளவில்லை எனில், கீழ்க்கண்டவை போன்ற விளைவுகள் நிகழலாம் என்று எனக்கு விளக்கிக் கூறப்பட்டிருக்கின்றன:

- நோயாளியின் மருத்துவ / உடல்நிலை மோசமடைதல்.
- இரத்த மாதிரிகளுக்காக திரும்பத்திரும்ப ஊசி குத்துவது.
- புறவெளி இரத்தநாள அணுகுவசதியை பெறுவதில் சிரமம்.
- அதிக அளவிலான வாசோபிரெசஸர்ஸ் தேவைப்படும்போது உறுப்பின் தொலைதூரப் பகுதிக்கு இரத்தஓட்டத்தடை

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை மூச்சுப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் மூச்சுத்தினறல் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவ, உங்களது / உங்களது நோயாளியின் மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. மூச்சுக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த மூச்சுக்குழல், ஆக்சிஜனை நுரையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும்.

சுவாசிப்பதற்கான இந்த குழாயின் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சுற்றி விரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். மூச்சுக்குழாய், குரல்வலைக்கு சற்றுகீழே தொடங்குகிறது மற்றும் மார்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு மூச்சுக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான மூச்சு சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த மூச்சு சிறுகுழாய், அதன்பிறகு நுரையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிரிகின்றன. மூச்சுக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்திசு ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. மூச்சை வெளியே விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. மூச்சுப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தருணத்தில் தான் மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது மூச்சு / காற்றுப்பாதையை அடைப்பின்றி திறந்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிஜன் தடையின்றி, தாராளமாக சென்று வருவதை இது அனுமதிக்கிறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களது நோயாளிக்குத் தேவைப்படக்கூடும்:

- உணர்விழப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவற்றைப் பெறுவதற்காக மூச்சுப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது / உங்களது நோயாளியின் நுரையீரலைப் பாதுகாப்பது
  சுவாசிக்க உதவ:
- சுவாசிப்பதை நோயாளி நிறுத்திவிட்டபோது அல்லது சுவாசிப்பதில் சிரமம் இருக்கும்போது
- சுவாசிப்பதற்கு நோயாளிக்கு உதவி தேவைப்படும்போது
- நோயாளிக்கு தலைக்காயம் ஏற்பட்டிருக்கும்போது மற்றும் தானாகவே அவரால் சுவாசிக்க இயலாதபோது
- ஒரு கடுமையான காயம் அல்லது நோயிலிருந்து மீண்டு வருவதற்காக நீண்ட காலஅளவிற்கு ஒரு நோயாளி உணர்விழப்பு மருந்தின் கீழ் அல்லது மயக்க நிலையின் கீழ் வைக்கப்படுவது அவசியமாக இருக்கும்போது.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது மூச்சுக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியிழுத்தல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

உடலுக்குள் ஊடுருவாத சுவாச ஏதுவாக்கல் முறையானது, சில சூழ்நிலைகளில் உதவிகரமாக இருக்கக்கூடும். ஆனால், மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியப்படும்போது, வேறு மாற்று சிகிச்சை முறைகள் வழங்கப்படுவதற்கு வழியில்லை.

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடைய திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பிற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுதிபட தெரிவித்துக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேர்வில், சில நேர்வுகளில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையோடு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன்.

இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள எனது நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.

	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
நோயாளி				
பதிலாள் / பாதுகாவலர் (பொருந்துமானால் #)		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)		
பதிலாள் ஒப்புதல் வழங்குவதற்கு காரணம்	நோயாளியால் ஒப்புதல் வழங்க இயலவில்லை; ஏனெனில்:			
சாட்சி				
மொழிபெயர்ப்பாளர் (பொருந்துமானால்)				

*ஆண்களுக்கு வலது பெருவிரல் மற்றும் பெண்களுக்கு இடது பெருவிரல் ரேகை பதிவு | #உரிய வயது வராதவராக அல்லது ஒப்புதல் கொடுக்க இயலாதவராக நோயாளி இருந்தால் மட்டுமே.

கீழே, கையொப்பமிட்டுள்ள மருத்துவராகிய நான், திட்டமிடப்பட்ட ஆபரேஷன் / நடைமுறை குறித்த தன்மை, ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள், கிடைக்கும்என்று கருதப்படும் நன்மைகள், எதிர்பார்க்கப்படும் நடைமுறைக்குப் பின் சிகிச்சை, மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் எடுத்துக்கூறி விளக்கியுள்ளேன். மேலும் அவர், இந்த ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					

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NABH

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/ICU/2022/040

Medway Heart Institute
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ICU PROGRESS NOTES

Date : 3/1/2024.
Time : 8:30 am
Doctor's Name : Dr. G. Anbu.

ICU SCORES *(as Appropriate)*
CLIF ACLF / AD score:
SOFA score:
MELD score:
SAPS II score:
AARC score:
APACHE II score:

ICU Day D2
Background
CAD — Awmi - S/P Lyn
[3-5TK (12/23) -
Mod - LVSD -

Issues last 24 hours
No Hpo chest pain/sym.
S/P IVUS guided PTCA to LAD & Major diagonal.

Central nervous system
Conscious / oriented / sedated with
Sedation score
GCS - E 4 V 5 M 6 15/15 Pupils B/L PERL
Pain score Drains NFNS.

Cardiovascular system
HR - 58/m Rhythm - NSR Cardiac Output -
BP - 110/66 CVP -
Cardiac Medications: S1S2 (+).

Respiratory system
Oxygen supplementation –
Saturation / PaO2- 95% - RA.
Ventilator : Spontaneous / Controlled

Last C x R - B/o (+)
Drains - RA - 20/m

GIT
P/A Soft.
Bowels – ~~Y~~/N Loose stools / Melena
Drains
NG tube : Y / N Day NGA-
USG
CT

Nutrition & Fluids
Oral feeds / NG feeds
TPN – formula used
Supplements
Calories / Proteins achieved :
IV fluids -
24 hour Urine output
Fluid balance
Creatinine clearance
Acidosis Lactate
RRT – SLED / IHD / CRRT

I 1000ml
O 1400ml
-400ml

Microbiology
Invasive lines
1. Peripheral line. 2.
Foley's Yes / No
ET Tube / Tracheostomy tube - Y / N Day
Culture reports

Antimicrobials with days
1. –
2.
3.

Labs
Hb TC Platelets
Urea 17 Creatinine 0.76
Na K
Bilirubin AST ALT
INR
Others

DVT prophylaxis – Y/N
Drugs : Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis – Y/N
Drugs
Pressure sore Y / N
Alpha bed Y / N

Plan for the day

- Drugs as per chart -
- Ifo chart -
- vitals Monitoring -
- Ward Rounds.

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. L. Neelam	91810	3/1/2023	8:40 am

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH202400011
Dr.G. GNANAVELU

MHI/IP/2022/041

Medway Heart Institute
...ry heart beat counts

DOCTOR'S PROGRESS NOTES

DATE	NOTES
	s/b Dr GG & Team
3/1/24 9AM	No complaints
	o/e
	conscious
	PR 52/min
	BP 110/72
	CVS - S1S2
	RS - B/L air entry
	puncture site - no hematoma
	Rec
	S1
	56/min
	TIV1-V6
	I/ 1800
	O/ 1400
	(+400)
	- Tablet ECG, Screening plan
	- ward shift
	(↓) - T. Metxl 12.5mg o-o-1
	- w/v Morning Metxl dose ℞
	39469

DATE	NOTES
8/1/24 10.00pm	S/B Dr. Anusuya
	patient reviewed.
	c/o: chestpain ↓ sed now.
	O/E: patient conscious, oriented
Vitals stable	S/E: CVS - S1S2 (P)
	RS - BAE (P)
	CNS - NFND
	Advice
	- monitor vitals
	- Continue tab drugs as per chart
	- W/F fevers spikes / desaturation / dehydration
K. Ravi 1345759	

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MHI/IP/2022/041

Mr. Gopinath
48y/M
202381395
202400011

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
4/1/24 9:40AM	S/B. Dr. Sujith. B. (Bmo)
	Cardio - post PTCA -
	Pt reviewed: - no complaints
BP - 110/70mmHg	O/E - pt conscious,
HR - 80bpm	oriented,
SpO2 - 95% in RA	Afebrile.
	S/E - CVS - S1 S2 (+)
Input / 1250ml.	RS - BAE (+) / NBS
Output / 2300ml.	PA - soft
	Adv
	- vitals monitoring
	- Follow drug chart
	- Inform SOS
	- w/R deterioration.
	BS 183573

DATE	NOTES
6/1/24	S/B Dr. Gnanavelu team
9:30 AM	
	- Pt reviewed
	No fresh complaints -
	O/E - Conscious, oriented
	- afebrile
	PR - 80/min, BP - 110/70.
	SpO2 95% RA
	CVS: S1S2 (+)
	RS: BAE (+)
	Adv
	- Cont the same.
	- plan d/c today
	9-21

MHI/IP/2022/065

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

DIABETIC CHART

ACTUAL WEIGHT 61.6 KG HbA1c –

PREVIOUS DIABETIC MEDICATIONS –

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
2/1/24	12.00	94 mg/dl	–		
2/1/24	17:10	99 mg/dl	–		DR. velmurugan
3/1/24	6:30	105 mg/dl	–		DR – Balaji

INSTRUCTIONS FOR INSULIN INFUSIONS

* Mix 40u short acting Insulin in 40 ml. of normal Saline (1U - 1 ml.)
* Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.
* Target Blood Sugar 150-200 mgs.
* To monitor K+ separately.

Urine Acetone

BLOOD SUGAR mg / dl	INSULIN INFUSION
< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.

MHI/IP/2022/069

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

BLOOD GROUP
"O" Positive

INVESTIGATION SHEET

Date	14/12/23	15/12/23	31/1/24			
HAEMATOLOGY						
Hb	14.9					
P.C.V	43.3					
Platelets	203000					
TLC	21800					
Polymorphs						
Lymphocytes						
Eosinophils						
Mono / Basophils						
E.S.R						
BIO-CHEMISTRY						
Urea	18	18	0.76			
Creatinine	0.9	0.7	17			
Sodium	136	136				
Potassium	4.9	4.2				
Bicarbonate	23	22				
Chloride	100	100				
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.9					
D.Bilirubin	0.2					
I.Bilirubin	0.70					
S.G.O.T	204					
S.G.P.T	42					
ALP	74					
GGT						
Total Protien						
S.Albumin	3.6					
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

Date	18/12/23	15/12/23				
COAGULATION PT / INR						
Fibrinogen						
D Dimer						
LIPID PROFILE						
Total Cholesterol		189				
Triglyceride		102				
H.D.L		42				
L.D.L		126.6				
VLDV		20.4				
THYROID FUNCTION T.S.H						
T.3						
T.4						
SEROLORY						
HIV						
HBsAg	Negative					
V.D.R.L						
COVID 19						
RT- PCR						
IgM Ig						
HBA1C						
FBS/PPBS						
RBS						
S.AMYLASE						
S.LIPASE						
C.R.P						
PROCALCITONIN						
DDIMER						
S.Osmolality **URINE**						
Osmolality						
Spot - Na						

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IP/2022/066

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Date	From: 2/1/24	To: 3/1/24	Bed No: 4W-4	INTAKE & OUTPUT CHART
24 Hrs : Started Time : 12.00		Ended Time : 7.00		
NPO Started at :		NPO Over at :		

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	300ml			
OUTPUT				

Total Intake: | Total Output: | Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
	Total intake cathlab.				200ml	200ml
11.15	100					300
~~3.00~~	~~200~~					
~~4.00~~	~~100~~					
~~6.55~~	100					
~~8.05~~	100					

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
14.10	200mL.					200mL		
16.55	500ml					700ml.		
11.20	~~400~~							
								Nurse
								0024

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Mr.GOPINATH
48/Male/MHI202381
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IP/2022/066
Medway Heart Institute
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INTAKE & OUTPUT CHART

Date	From: 3/1/24 To: 4/1/23	Bed No: GENERAL WARD.	
24 Hrs : Started Time :	7:00	Ended Time :	7:00
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	350ml	500ml	400ml	
OUTPUT	200ml	800ml	700ml	

Total Intake: 1250ml Total Output: 2300ml Difference: -1050ml

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
				Total intake	= 250 ml	
				Total output	= 600ml in dcu @ 10:00	
11.15	100					350
13.00	200					550
14.20	100					650
16.50	100					750
18.00	100					850
22.30	150ml					1000ml
2.00	150ml					1150ml
5.30	100ml					1250ml

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
11.20	400					300		
16.55	500					1300		
18.00	300					1600		
22.30	250ml					1850ml		
2.00	250ml					2100ml		
6.00	200ml					2300ml		
		TOTAL	INTAKE	-	1250ml			
		TOTAL	OUTPUT	-	2300ml			

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...OPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IP/2022/066
Medway Heart Institute
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INTAKE & OUTPUT CHART

Date From: 4/1/24 To: 5/1/24			Bed No: Aw-1
24 Hrs : Started Time : 7.00		Ended Time : 7.00	
NPO Started at :		NPO Over at :	

SHIFT	Morning	Afternoon	Night	Restricted Fluid (RF)
INTAKE	800			
OUTPUT	780			

Total Intake: Total Output: Difference:

INTAKE (ml)

Time	Oral	Tube Feeding	Intravenous Infusion			Total
			Type of Fluid	Additions	Amount	
6.30	100					100
8.50	250					250
10.00	150					500
11.30	100					600
12.30	200					800

OUTPUT (ml)

Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
8.30	300					300		
10.00	250					550		
12.00	200					750		
								Nea
								0224

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'MHI/IP/2022/074

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

VITAL INFORMATION SHEET

BLOOD GROUP	
ON ADMISSION	
Height in CM	Weight in Kg.
168	61.6kg.

Diagnosis: CAD - Acute MI.

Procedure : PTCA to LAD & major diagonal was guided.

NO. OF DAYS		DOA	D-1	DAY-2	
DATE		2/1/24	3/1/24	4/1/24	
HOUR	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6
PULSE		60	50	60bpm	80b/m
RESP		16	16	16	20b/m
B.P.		116/76	106/69	100/60	110/70
SPO2		97%	90%	98%	95%
DAILY WEIGHT		61.6kg	61.6kg.		
24 HRS INTAKE		1000ml	1250ML		
24HRS OUTPUT		1400ml	2300ML		
BALANCE		400			
MOTION		X	T	T	T

40.5° 40° 39.5° 39° 38.5° 38° 37.5° 37° 36.5° 36°

Temperature 98°F

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EARLY WARNING SCORE MONITORING CHART

Name: _____ Age/Sex: _____ Patient Id No: _____

NEWS key 0 1 2 3	DATE / TIME													DATE / TIME
A+B Respirations Breath/ min	>25													>25
	21-24							2						21-24
	18-20													18-20
	15-17													15-17
	12-14													12-14
	9-11							1						9-11
	<8													<8
A+B SPo2 Scale 1 Oxygen Saturation (%)	>96													>96
	94-95							1						94-95
	92-93							2						92-93
	<91													<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 % eg: In hypercapnic respiratory failure only use scale 2 under the direction of qualified clinician	>96 on oxygen													>96 on oxygen
	95-96 on o2							2						95-96 on o2
	93-94 on O2							1						93-94 on O2
	>93 on air													>93 on air
	88-92													88-92
	86-87							1						86-87
	84-85							2						84-85
	<83%													<83%
Air or Oxygen ?	A= Air													A= Air
	O2litre/ min							2						O2litre/ min
	Device													Device
C Blood Pressure	>220													>220
	201-219													201-219
	181-200							2						181-200
	161-180													161-180
	141-160													141-160
	121-140													121-140
	111-120													111-120
	91-100							1						91-100
	81-90							2						81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	<50													<50
Diastolic BP	mmHg	70		70	70	70	76	80	80					mmHg
C Pulse Beats / min	>131													>131
	121-130							2						121-130
	111-120							2						111-120
	101-110							1						101-110
	91-100							1						91-100
	81-90													81-90
	71-80													71-80
	61-70													61-70
	51-60													51-60
	41-50							1						41-50
	31-40													31-40
	<30													<30
D Consciousness Score for New onset of confusion (no score if chronic)	Alert													Alert
	Confusion													Confusion
	V													V
	P													P
	U													U
E Temperature Degree Celsius	>39.1 degree Celsius							2						>39.1 degree Celsius
	38.1-39.0							1						38.1-39.0
	37.1-38.0													37.1-38.0
	36.1-37.0													36.1-37.0
	35.1-36.0							1						35.1-36.0
	< 35.0													< 35.0
NEWS Total		0		0	0	0	0	0	0					
Monitoring Frequency		4hrly		4hrly	4hrly	4hrly	4hrly	4hrly	4hrly					
Escalation of Care Y/N		No		No	No	No	No	No	No					
Initials by RN														
Initials by Sr. RN														

Note: Nurses are trained to Call Code 99 (100) when they get score of 3 in any single parameter or aggregate score of > 5

Score and monitoring frequency	4	Every Hourly
	3	Every 2nd Hourly
	2	Every 4th Hourly

MHI/DIET/2022/147

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02/01/2024/IPH2024000011
Dr.G. GNANAVELU

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: AVS | Acute Occlud AWMI | EF-38% | PTCA | CAD

Height: 168 cms | Weight: 64.6 Kgs | Food allergies: Yes/ ~~No~~; if yes, specify.....

Religious Beliefs: ☐ Vegetarian ☐ Non Vegetarian ☑ Eggetarian ☐ Jain

Diet Prescription: 1000 calorie, 60 fat, 6g salt, 1000ml fluid restricted diet.

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

	(A) - Patient's related Medical History					
	1) Weight Change (overall change in past 6 months)					
		☑ 1 No weight change/ gain	☐ 2 <5%	☐ 3 5 - 10%	☐ 4 10 - 15%	☐ 5 >15%
2)	Dietary Intake	Duration:				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Oral	No change	Sub - optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo - caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo - caloric feeds	Starvation
3)	Gastrointestinal Symptoms Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4)	Functional Capacity (Nutrition related functional impairment) Duration:					
		☑ 1 None /Improved	☐ 2 Difficulty with ambulation	☐ 3 Difficulty with normal activity	☐ 4 Light activity	☐ 5 Bed / chair - ridden with no or little activity
5)	Co - morbidity (Disease and its relationship to nutrition requirements)					
		☐ 1 Healthy	☐ 2 Mild co - morbidity	☑ 3 Moderate co - morbidity/ age >75 years	☐ 4 severe co - morbidity	☐ 5 Very severe multiple co - morbidity
B)	Physical examination					
1)	Decreased fat stores or loss of subcutaneous fat					
		☑ 1 Normal	☐ 2 Mild	☐ 3 Moderate	☐ 4	☐ 5 Severe
2)	Sign of muscle wasting					
		☑ 1 Normal	☐ 2 Mild	☐ 3 Moderate	☐ 4	☐ 5 Severe
Total Score = Sum f above 7 components						
Nutritional Status : Based on this patient is						
	Well Nourished	☑ (7 to 14)				
	Moderately Malnourished	☐ *(15 to 18)*				
	Severely Malnourished	☐ (19 to 35)				
Nutrition Intervention:						
	☑ Oral	☐ Enteral	☐ Parenteral			
Diet counselling provided:	☑ Yes	☐ No				
Frequency of re-assessment:	☑ Weekly	☐ Fort - night	☐ Monthly			
Enteral / Parenteral	☐ Daily	Calorie count:	☐ Yes	☑ No		

Dietitian Signature / Name / Date / Time: 2/1/24 18:00

Maria Catherine John
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
2/1/24, 18:00	A 48 year old male came c̄ c/o chest pain since (1 month) was assessed to be well nourished as evident by SGA. KCO – AU | ACVM Patient shifted to Cathlab for procedure (PCI). Patient visited to CCU. NOW on Patient tolerated liquid diet. Can initiate on soft solid diet.	[signature] Maria Catherine John Senior Dietitian.
3/1/24, 11:40	Patients visited board. Reemphsized on the diet restriction. Motivated to eat well.	[signature] Maria Catherine John Senior Dietitian
4/1/24 10:00	Oral intake is good. Educated the patient and family on 1600 calories low fat, low salt, 2000 ml fluid restricted diet on discharge. Emphsized on small frequent meals. Diet modification and clarification done. Diet chart given on discharge.	[signature] Maria Catherine John Senior Dietitian

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PRE/POST OPERATIVE ECHO

Mr.GOPINATH R
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02/01/2024/IPH2024000011
Dr.G. GNANAVELU

Date & Time	Screening Echo Report
03/01/2023	
9.56 Am	S/P PTCA
	- All chambers normal sized.
	- RWMA present :- All Apical segments, Apex, mid Anterior hypokinetic.
	- mild LV systolic dysfunction.
	- Normal RV systolic function.
	- All Valves structurally normal
	- IAS / IVS Intact
	- Trivial MR
	- Trivial TR / mild PAH
	- IVC normal in size and collapsing.
	- No clot / vegetation / Effusion.
	HR: 55 bpm
	LVIDD : 50 mm LVIDS : 38 mm EF : 46 % EF By simpson's Method EDV : 115 ml ESV : 53 ml EF : 46 % RVIDI : 18 cm/s TAPSE : 26 mm TR Gt : 30 mmHg RVSP : 40 mmHg
	Done By - Ms. Lokeshwari. k (Cardiac tech) MHI0180

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02/01/2024/IPH2024000011
Dr.G. GNANAVELU

PSYCHOLOGICAL WELLBEING REPORT

Date: 04/01/24 Time: 11.30 am.

Unit: CW-3

Clinical diagnosis: P

Surgery/ Procedure: PTCA - LAD.

Impression: Smoking (+), work stress +: 3m.

- calm affect, oriented, responsive.
- sleep & appetite (N)
- work stress +: 3m - resolved now
- smoking abstinence (: 15 days)
- motivated to quit substance & take care of health.

Employee ID: MH1027/PSY

Signature of the Psychologist:

JCI ACCREDITED NABH ACCREDITED

MRD

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TRANSRADIAL PERCUTANEOUS CORONARY INTERVENTION REPORT

IVUS GUIDED

Patient name	**MR. GOPINATH**	**ID**	**MHI202381395**
Age/Gender	**48 M**	**IP No.**	**IPH2024000011**
Cath No.	**3518-3519**	**D.O.P.**	**2.1.2024**

Done by Dr. G.Gnanavelu

Technician : Mr. Prathap

Scrub nurse : Ms. Sharmila

DIAGNOSIS : RECENT AWMI; MILD LV DYSFUNCTION
SIGNIFICANT LAD-D1 BIFURCATION STENOSIS – MEDINA 1,1,1

APPROACH : Right radial artery

EXPOSURE TIME: 3830 sec

HARDWARE : 6F hemostatic sheath, 6 F EBU 3.0 guide

RAK: 649 mGy

CONTRAST : OMNIPAQUE 350 ml

DAP : 260 Gy.cm2

MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 10000 IU IA; Inj Fentanyl 25mcg IV

HEMODYNAMIC DATA: ABP 114/76 (89) PULSE 56 bpm SPO2 100%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
MID LAD	Bifurcation MEDINA 1.1.1 Critical	BMW in LAD & DIAGONAL WHISPER TO RECROSS DIAGONAL	2 X 12 SC Diagonal & LAD 12 atms	ONYX 2.25 X 18 in DIAGONAL 2.5 X 26 in LAD	2.5 X 10 NC In diagonal 3 x 8 NC For crushing; Postdilatation and KBI; 3 X 8 for POT 20 atms	TIMI III FLOW & MPG III

REMARKS: Minicrush technique was used for this bifurcation stenosis. IVUS was used in LAD after postdilatation of LAD stent and before completion of final KBI of LAD and diagonal stents. Stents appeared optimally deployed without malapposition and edge dissection. KBI was done with 2.5 x 10 NC in Diagonal and 3 X 8 NC in LAD and POT done at 20 atms with good result.

RESULT: SUCCESSFUL BIFURCATION PTCA X LAD –DIAGONAL WITH MINICRUSH TECHNIQUE

Dr. G. GNANAVELU, MD, DM

Dr. G. Gnanavelu MD, DM (cardio), F
Cardiologist
2469

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இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வார்டு படுக்கை எண்:	யுஹெச்ஐடி (UHID) :

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் ..... அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளள காண்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த காண்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிட்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிட்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (பலூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம்

ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு, இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I)இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) காண்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் ..... அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில், எனக்கு இரத்தமேற்றுதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார், இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்திரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழிபெயர்ப்பாளர்				

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/111

Medway Heart Institute
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PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: AWMI, CAD. **Allergies if any:** _____

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
4W-4	cath lab	2/1/24	14:30	PTCA

Method of Transfer: ☐ On Bed ☑ On Wheelchair ☐ On Stretcher

ASSESSMENT OF PATIENT:
General condition of Patient: ☑ Conscious ☐ Semi-conscious ☐ Un-conscious

Language Barrier: ☐ Yes ☑ No ☐ If Yes, specify: _____

Fall Risk Category: ☑ Low Risk ☐ Medium Risk ☐ High Risk

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.F	20	55	96	110/70	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

	Signature	Name	Emp. No.	Date	Time
Handover by		M. Revathi	0225	2/1/24	14.30
Handed over to		Bharatharaj	0176	2/1/24	14.30

After Procedure:
Procedure completed: ☑ Yes ☐ Yes | Any critical information: Nil

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.2	22 br/mt	66 bt/mt	100%	133/73/93	0/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

	Signature	Name	Emp. No.	Date	Time
Handover by		Bharatharaj	0176	2/1/24	17.00
Handed over to		Ramya.J	0270	2/1/24	17.00

JCI ACCREDITED NABH ACCREDITED

Medway Heart Institute

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TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mr. GOPINATH.R		ID:	MHI202381395
Age/Gender :	48 M		IPH:	IPH202302554
Cath No. :	3435		DOP:	20.12.2023
Done by		Assisted by	Technician	
Dr.Gnanavelu/Dr.Salaisudhan		Ms. Abinaya	Mr. Ram	

DIAGNOSIS: CAD; AWMI-LYSED STK(12/2023); MODERATE LV DYSFUNCTION

Access: Right Radial artery — Total exposure time: 3'58"

Hardware used: 5F sheath, 5F TIG — DAP : 10.5 Gy.cm2

Contrast used: CONTRAPAQUE 40 ml — Total RAK: 108 mGy

Medications given: Inj NTG 200 mcg & Inj Heparin 2500 IU IA

Hemodynamic data: Ao Pressure – 90/50(63) mmHg, HR – 76/min, Spo2 – 99%

Selective coronary angiogram done in multiple angulated views :

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCX
LAD	Type 3 vessel. Proximal LAD shows luminal irregularities. Mid LAD astride first diagonal shows 90% tubular stenosis. Distal LAD after third diagonal shows 70% tubular stenosis. Gives 3 diagonals. First diagonal is a major vessel, ostioproximal part shows 70% tubular stenosis. Second diagonal shows diffuse disease. Third diagonal shows luminal irregularities.
LCx	Non Dominant. Proximal LCX shows luminal irregularities. Distal LCX is a thin vessel with luminal irregularities. Gives 3 OMs. OM1 is an early and major vessel, shows luminal irregularities.
RCA	Dominant. Proximal RCA appears normal. Mid RCA shows 20% discrete stenosis. Distal RCA appears normal. PDA and PLv appear normal.

FINDINGS: RIGHT DOMINANT; SIGNIFICANT LAD & DIAGONAL BIFURCATION DISEASE

ADVICE: IVUS GUIDED PTCA TO LAD (2 STENTS)

Dr. G. GNANAVELU, MD, DM

Mr. Gopinath
48 yrs / M
MHI2023381395
Dr. Gnanavelu

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
2/1/24	Cath Lab	
14.25	⇒ Pt Received from IInd floor to Cath Lab. Conscious and oriented.	
14.30	⇒ Vitals stable IV line Rt and left side patent. VIP Score 0	
14.35	⇒ IVF: NS 30ml/hr IV started Sterile draping done. PTCA + IVUS procedure started.	
14.40	⇒ Inj: Fentanyl 25 mcg + Inj: Emeset 4mg IV given 0/B Dr. GBG (Sir)	
14.45	⇒ Rt Radial arterial approach under Local anesthesia.	
14.45	⇒ Inj: NTG 200 mcg + Inj: Heparin 5000 IU given 0/B Dr. GBG (Sir).	
14.45	⇒ BP: 116/76 (91) mmHg, HR: 60 bt/mt. SPO2: 99% vitals Stable.	
15.00	⇒ Inj: Heparin 2500 IU IV given 0/B Dr. GBG (Sir)	
15.30	⇒ BP: 124/70 (94) mmHg, HR: 64 bt/mt SPO2: 100% vitals stable.	
15.45	⇒ ACT - 245 secs checked.	
15.48	⇒ Inj: Heparin 2000 IU IV given 0/B Dr. GBG (Sir)	
16.10	⇒ Inj: Tirofiban 10 ml Bolus IV given 0/B Dr. GBG (Sir)	
16.30	⇒ BP: 133/83 (100) mmHg, HR: 66 bt/mt SPO2: 100% vitals stable.	
16.35	⇒ ACT = 224 secs Checked.	
16.40	⇒ Inj: Heparin 1000 IU IV given 0/B Dr. GBG (Sir)	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Sathiya	0016	2/1/24	16.40

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
2/1/24	=> procedure PTCA+IVUS done.	
16.45	Rt Radial arterial sheath removed. Tight Plaster bandage applied. no oozing & hematoma	0176
17.00	=> PE shifted to CCU all reports hand over to R/N. Ramya.	0176

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Sathiya	0016	2/1/24	

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SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

mr. Gopinath
46yrs IM
MH1202381395
Dr. Ginanavelu

MHI/OT/2022/086

Medway Heart Institute
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Name of the Procedure : PT LA. +IVUS Location : Cath Lab. Date & Time : 2/1/24

PATIENT LABEL

Does the Procedure involve Procedural Sedation : ☑ Yes ☐ No

SIGN IN 14.35 Before Induction of Procedural Sedation		TIME OUT 14.45 After procedural Sedation and before procedure		SIGN OUT 16.45 When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure		
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures
Identity by two identifiers	☑ Yes	Identity by two identifiers	☑ Yes	Name of the Procedure done written down ☑ Yes PT LA + IVUS
Procedure	☑ Yes	Procedures PT LA +IVUS	☑ Yes	Name and site of all specimens / investigations ☑ Yes ☐ NA confirms labeling and sent to lab
Side	☑ Rt ☐ Lt ☐ NA	Side Rt Radial arterial approach	☑ Rt ☐ Lt ☐ NA	
		Expected Blood loss N.A.		
Consent	☑ Yes	Position supine.	☑ Yes	Any recovery concerns : ☐ Yes ☑ None
Known Allergy	☐ Yes ☑ No If yes, plaese specify	Consent	☑ Yes	If Yes, Pls. specify :
		Required equipment and implants available	☑ Yes ☐ NA	
Difficult airway / aspiration risk / dentures	☑ No ☐ Yes, equipment and assistance available	Essential Imaging displayed	☑ Yes ☐ NA	
		Antibiotic prophylaxis within last 60 minutes	☐ Yes ☑ NA	
Possibility of hypothermia	☑ No ☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☑ None
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☑ NA	If Yes, Pls. specify :
All concerned anesthesia equipment and medication check complete		Anticipated duration briefed	☑ Yes	
☐ Spo2 ☐ NIBP ☑ Others pls. specify ECG		Anticipated blood loss briefed	☐ Yes ☑ NA	
Pre OP medication taken	☐ Yes ☑ No	Adequate fluids and blood available	☑ Yes ☐ NA	
		Team briefed on any critical or unexpected steps	☑ Yes	Corrective action :
Required equipment for procedure available	☐ Yes ☐ NA	For procedural sedation cases		
		Any patient specific concerns :	☐ Yes ☑ None	
		Intra procedure glycemic control	☐ Yes ☐ NA	
		Any concerns about sterility	☐ Yes ☑ None	

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : RN. Sathiya 0016	Technician : Mr. Pandiyan 2501	Others Please Specify :
Date : 2/1/24 97241	Date : 2/1/24 97241	Date : 2/1/24	Date : 2/1/24	Date :
Time : 16.55	Time : 16.55	Time : 16.55	Time : 16.55	Time :

MHI/CATH/2022/085

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Procedure Monitoring Sheet (Cath Lab)

Patient Name : Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

UHID / IP :

Consultant :

Age / Sex : 48Y/M

Ward Unit : UW-4

Diagnosis : CAD - AWMI

Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse)

PARAMETERS	YES	NO	NA
Vital signs : BP: 110/70 Temp: 98°F Pulse: 55 RR: 20 SPO2: 96	✓		
Urine voided	✓		
Bowel preparation		✓	
Pre-procedure medication administered		✓	
Procedure site marked	✓		
Skin preparation done	✓		
NPO	✓		
Loose Tooth removed		✓	
Contact lenses / Eye glasses removed		✓	
Prosthesis present			✓
Jewellery/Nail polish removed	✓		
Checked for Allergies (Drug / food)	✓		
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse :		Date & Time : 2/1/24 at 14.30	

Intra – Procedural Record (To be filled by the Cath Lab Nurse)

Time	HR / min	RR / min	BP mmHg	SpO_2%	Medication / Remarks	Sign. of Nurse
2/1/24						
14.35	64 bt/mt	22 br/mt	110/70 (84)	96 %	-	
14.45	60 bt/mt	22 br/mt	116/76 (91)	99 %	-	
15.15	64 bt/mt	22 br/mt	124/70 (94)	100 %	-	
15.45	68 bt/mt	22 br/mt	120/80 (92)	100 %	-	
16.15	62 bt/mt	22 br/mt	128/80 (95)	100 %	-	
16.-	66 bt/mt	22 br/mt	138/83 (93)	100 %	-	
		procedure got over				

Post Procedure Follow Up Data (to be filled by the doctor)

Time : 16.55 Route : Rt Radial arterial approach

Complication : Nil

BP : 124/80(94) mmHg, HR : 70 bt/mt, RR : 22 br/mt, SpO2 : 100%

Distal Pulse: felt., Puncture Site: no oozing & hematoma

Advise:

- Shift To: Ward / ICU
- Bed rest up to 6 hours
- Observe puncture site for bleeding
- Watch for Pulse in Rt Radial artery.
- Diet Normal

- Inform Duty Medical Officer SOS
  a) If patient complains of any Discomfort
  b) If dressing is Loose or Socked with Blood
  c) If limbs are Cold / Absent Pulse.
- Remove Rt Radial arterial dressing on 3/1/24 at 14.00 AM /PM after informing to the consultant.
- Special instruction if any: Nil

Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse

Nurses Notes :

Procedure PTCA done. Rt Radial arterial sheath removed. right plaster bandage applied. no oozing & hematoma

Condition at the end of procedure : ☑ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☑ CCU ☐ Other _____

Name & Signature of the Nurse :

Date & Time : 2/1/24 @ 17.00

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/053

Medway Heart Institute
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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 2/1/24 Time of Arrival: 12:30 Mode of Admission: ☑ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☑ Yes ☐ No If Yes, Name of the Relative: _____

Relationship with Patient: _____ Contact Person's Name: Mrs. selvi Relationship: wife

Contact No.: 9380597138 Primary language spoken: ☑ Tamil ☐ English ☑ Indian ☐ International

Interpreter needed: ☐ Yes ☐ No

Patient status: ☑ Conscious ☐ Unconscious ☐ Disoriented | Patient Vulnerable: ☐ Yes ☑ No

Menstrual History : LMP : — Menopause: _____

Medical History : DM / HTN / Co - Morbility : — Yes If yes specify

Drugs History : Antiplatelet — (Specify)

Psychological Status: ☑ Calm ☐ Anxious ☐ Withdrawn ☐ Agitated ☐ Depressed ☐ Sleeping Difficulty

Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☑ No

If Yes, specify details: _____

Socio Economic Status: ☐ Employed ☐ Retired ☐ Own Business ☐ Home-Maker ☐ Others: _____

Vital Signs: Temp: 98.2 (°F) | Pulse / HR: 55bpm (beats/min) | BP: 110/69 (mmHg)

Respiration: 20bpm (breaths/min) | SpO_2: 96 (%) | CBG: 94 (mg/dl) | Height: 168 (cms) | Weight: 62 kg (kgs)

Allergies / Adverse Reaction: ☐ Yes ☑ No ☐ Medication ☐ Blood Transfusion ☐ Food ☐ Not known

If Yes, specify: _____

Pain: ☐ Yes ☐ No. If Yes, Score: 1/10 **Pain Scale Used:** ☐ Wong-Baker FACES Pain Rating Scale (7-12 years) ☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: — Location: —

Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:

Last 3 months Appetite: ☐ Increased ☐ Decreased ☐ No Change

Last 3 months Weight: ☐ Increased ☐ Decreased ☐ No Change

Type of Patient: ☐ Diabetic ☐ Non Diabetic Type of Diet: Normal diet

Dietician Informed: ☑ Yes ☐ No. If Yes, mention the Name: Ms. Catherine. Time: 13:00

Orient Patient if: ☐ Conscious **Orient Patient Attendant if:** ☐ Unconscious ☐ Disoriented

☐ Room ☐ Side Rails ☐ Toilet Bell ☐ Patient Information Board ☐ Bathroom ☐ Bed Controls

☐ Use of Footstool ☐ Grab Bars ☐ Nurses Call Bell ☐ Television ☐ Light Controls ☐ Telephone

Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	☐ Yes ☑ No		
Hearing Impairment	☐ Yes ☐ No		
Chewing Difficulty	☐ Yes ☐ No		
Walking Difficulty	☐ Yes ☐ No		

Daily Activity Of Living:

Activity	Independent	Assisted	Dependent
Bathing	☑	☐	☐
Dressing	☑	☐	☐
Eating	☑	☐	☐
Walking	☑	☐	☐
Toilet Use	☑	☐	☐

Pressure Injury Risk Assessment: Braden Scale

Sensory Perception	Score	Moisture	Score	Degree of Activity	Score
No Impairment	4	Rarely Moist	4	Walks Frequently	4
Slightly Limited	3	Occasionally Moist	3	Walks Occasionally	3
Very Limited	2	Very Moist	2	Chair Fast	2
Completely Limited	1	Constantly Moist	1	Bed Fast	1
Mobility	**Score**	**Nutrition**	**Score**	**Friction & Shear**	**Score**
No Limitation	4	Excellent	4	No apparent problem	3
Slightly Limited	3	Adequate	3	Potential Problem	2
Very Limited	2	Probably In-Adequate	2	Problem Present	1
Completely immobile	1	Very Poor	1		

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

Total Score: 23 Action needed: ☐ Yes ☒ No Pressure injury present at the time of admission: ☐ Yes ☐ No

If yes, Location:_____ Grade:_____ Size: _____

Witnessed by:_____ Signature:_____ Relationship:_____

MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

Fall Risk Assessment (Modified Morse Scale):

Variables		Numeric Value
History of falling (immediate or within 6 months)	No	0
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	15
Ambulatory Aid		
None / Bed Rest / Nurse Assist		0
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
Gait		
Normal / Bed Rest / Wheel Chair		0
Weak		10
Impaired		20
Mental Status		
Oriented to own stability		0
Overestimated or forgets limitations		15
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics	No	0
	Yes	15
Score Interpretation: *0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk* **Total Score**		15

As per the score, tick the following appropriate boxes:

Low Risk Interventions (0 - 24)

- ☐ Familiarize the patient with the immediate surroundings
- ☐ Remind the patient to use call bell before getting out of bed
- ☐ Keep the two side rails in the raised position at all times for all patients regardless of age
- ☐ Keep the call bell, bedside table, water, glasses within the patient's easy reach
- ☐ Remove excess equipment or furniture to make a clear path
- ☐ Keep the patient's bed in the low position at all times except during procedure
- ☐ Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed
- ☐ Bed wheels should be locked
- ☐ Encourage family participation in the patient's care
- ☐ Ensure that floor of the bathroom is dry and not slippery
- ☐ Review medications for potential side effects that can promote falls
- ☐ Use safety belts during movement in wheelchair
- ☐ The patients are not ambulated by themselves. They are to be ambulated only with assistance

Medium risk interventions (25 - 44)

- ☐ Apply all the low risk interventions
- ☐ Tie yellow fall risk tag in the bed and Wheel chair / Stretcher
- ☐ Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat
- ☐ Use restraints and bed monitors as ordered by the doctor
- ☐ Allow the patient to ambulate only with assistance
- ☐ Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care
- ☐ Do not leave patients unattended in diagnostic or treatment areas
- ☐ Accompany the patient while going to bathroom
- ☐ Advice the patient to use grab bars near the toilet, bathtub, and shower
- ☐ Make sure the family and other visitors understand the restrictions mentioned above

High-risk interventions (above 45)

- ☐ Apply all the low and medium risk interventions
- ☐ Tie red fall risk tag in the bed, wheel chair and stretcher
- ☐ Locate the high-risk patients in a room close to the nurses' station
- ☐ Answer these patients call bells as quickly as possible
- ☐ Provide a commode at bedside (if appropriate)
- ☐ Urinal / bedpan should be within easy reach (if appropriate)
- ☐ Encourage family members or other visitors to stay with them
- ☐ If appropriate, consider using protection devices: safety belts

Initial Assessment to Special Needs and Vulnerability of Patient:

	Yes	No	Remarks *(please specify)*
Terminally ill patients		✓	
Patients with intense chronic pain		✓	
Woman in labor or experiencing termination of pregnancy		✓	
Patients with emotional or psychological distress		✓	
Patient suspected of drug or alcohol dependency		✓	
Victims of abuse and neglect		✓	
Patients whose immune system is compromised		✓	
Patient with infections and communicable diseases		✓	
Does the patient have implants		✓	
Has tracheotomy been done		✓	
Has colostomy been done		✓	
Any other potential needs of the patient			

DVT RISK ASSESSMENT

Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

S. No.	Parameters	Yes / No	Score
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	☐ Yes ☑ No	0
2	Bedridden recently >3 days or major surgery within four weeks	☐ Yes ☑ No	0
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	☐ Yes ☑ No	0
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	☐ Yes ☑ No	0
5	Entire leg swollen (Assess for both legs)	☐ Yes ☑ No	0
6	Localized tenderness along the deep venous system (Assess for both legs)	☐ Yes ☑ No	0
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	☐ Yes ☑ No	0
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	☐ Yes ☑ No	0
9	Previously documented DVT (Assess for both legs)	☐ Yes ☑ No	0
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	☐ Yes ☑ No	0

Risk Score Interpretation (Probability of DVT): **Final Score** 0

Tick the score obtained (✓)

		✓	Action Taken	Date	Time
Low Risk	**-2 to 0**	0	Low		
Moderate Risk	**1 to 2**				
High Risk	**3 to 8**				

Personal Belongings / Valuables:

Valuables	Description	With Patient	With Patient's Attendant	Name & Signature of the Patient / Patient's Attendant	Remarks
Dentures	☐ Upper ☐ Lower ☐ Both ☑ Nil				
Hearing Aid	☐ Right ☐ Left ☑ Nil				
Eye glasses / Contact lens	☐ Yes ☑ No				
Jewellery	☐ Yes ☑ No				
Other valuables *(specify)*					

Report (List of X-ray, ECG, lab reports retained with the nurse): _____

	Sign.	Name	Emp. No.	Date	Time
Patient / Patient's Attendant	G. Selvi	G. SELVI	*Relationship* WIFE	2/1/24	13:00
Nurse		M. Daisy		2/1/24	13:00
Unit In-Charge	Nee	Nalini		2/01/24	13:00

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NABH ACCREDITED

Mr.GOPINATH R
48/Male/MHI2023S1395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 2/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: CAD - AWMI
GCS: 15/15
NEWS / PEWS Score: 0
POD: –
Ventilator day: –
Central line days: –
Peripheral line day: Right: – Left:
Ryle's Tube: ☐ Yes ☑ No Day:
VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☐ No. If Yes, specify organism: –

B — BACKGROUND

Type of surgery: –
Date of surgery: –
Allergies if any: NKDA
On room air / oxygen: RA
IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 98.(°F) | Pulse / HR: 55 (beats/min) | Respiration: 20 (breaths/min)
BP: 110/70 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 66 (kgs) | BMI: 21.8kg/m2
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ☑ NRS / CPOT
Fall Risk Score: 35 **Fall Risk Protocol:** ☐ Low ☑ Medium ☐ High
Braden Score: ☑ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ No ☐ NA Wound Dressing done: ☐ Yes ☑ No ☐ NA
Current diet: Normal diet
Drains: –

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Nil
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☐ No. If Yes, modified care plan date: –
Pending follow-up orders: –
Special instructions if any: Today PTCA Plan.

	Signature	Name	Emp. No.	Date	Time
Handover given by		M. Revathi	0025	2/1/24	14.30
Handover taken by		Bharatharaj	0176	2/1/24	14.30
Document endorsed		Nalini	0024	02/01/24	14.30

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
2/1/24 at 12.30	Admission Note. => Patient got admited on General Ward 4 bed. => Conscious & Oriented. => Vital checked & recorded. => Patient hemodynamically stable. => ID Band waard. => Today Plan PTCA.	0025 0025
13.00	=> Preperation done & consent taken. => IV line inserted. Shifting Note. => patient shifted to cath lab => Pt hemodynamically stable. => EST Note given to Cath lab staff. => Patient handing over given to cath lab staff.	0025 0025

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nee	Nalini	0024	02/01/24	14.30

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Patient ID
Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 2/1/24 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: CAD - AWMI / dyslipidemia s/p PTCA (12/23) GCS: 15/15
NEWS / PEWS Score: POD: —
Ventilator day: Central line days: —
Peripheral line day: Right: brachial Left: brachial.
Ryle's Tube: ☐ Yes ☐ No Day: VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: PTCA to LAD & major diagonal + IVUS Guided. Date of surgery: 24/24
Allergies if any: NKDA
On room air / oxygen: on room air. IV fluids on flow: IVF NS 30ml/hr.
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 97.4 (°F) | Pulse / HR: 59 (beats/min) | Respiration: 16 (breaths/min)
BP: 110/74 (mmHg) | SpO_2: 99 (%) | Height: 168 (cms) | Weight: 61.6 (kgs) | BMI: 21.8 kg/m2
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 35 **Fall Risk Protocol:** ☑ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: (N) diet Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Trop I, urea, creatinine
Critical value alert and its corrections: 2. echo normal
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: _____
Pending follow-up orders:
Special instructions if any: NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by		Ramya. S	0257	2/1/24	19:30
Handover taken by		Nathiya	0240	2/1/24	19:30
Document endorsed			0002	2/1/24	17:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
2/1/24 @ 17:00	patient received from cath lab in stable condition vital parameter is normal. pt undergone he prcA fr LAD & major diagonal + DES Guided in ® radial approach procedure site no oozing no haematoma	
17:30	pt bed Twice no special complaints.	
18:00	baby v/s checked & recorded	
19:00	T. pan 40mg given	
19:30	pt handed over to next duty staff	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Jayadevi	0002	3/1/24	19:00

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Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 2/1/24 Shift: ☐ Morning ☐ Evening ☑ Night

S

SITUATION

Diagnosis: CAD - DVD MI | Lyced c STEMI (12/23) GCS: 15/15
NEWS / PEWS Score: — POD:
Ventilator day: — Central line days:
Peripheral line day: Right: brachial Left: brachial
Ryle's Tube: ☐ Yes ☑ No Day: —
Urinary Catheter: ☐ Yes ☑ No Day: VIP Score:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:

B

BACKGROUND

Type of surgery: PTCA to LAD, Mapping diagonal with IVUS GUIDANCE Date of surgery: 2/1/24
Allergies if any: NKDA
On room air / oxygen: RA IV fluids on flow: IVF NS - 30 cc/hr
Complaints / New Symptoms in last shift: —

A

ASSESSMENT

Vital Signs: Temp: 98.6 °F) | Pulse / HR: 79 (beats/min) | Respiration: 20 (breaths/min)
BP: 119/78 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 61.6 (kgs) | BMI: 21.8 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 35 **Fall Risk Protocol:** ☑ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: (N) diet Drains: —

R

RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations: Screening Echo
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: —
Pending follow-up orders: —
Special instructions if any: Plan shift to Ward.

	Signature	Name	Emp. No.	Date	Time
Handover given by		Nathiya	DPHO	31/1/24	7:30
Handover taken by		S Premalatha	0211	31/1/24	7:30
Document endorsed		Jayashree	0002	2/1/24	10:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
2/1/24 @ 19:30	→ Night duty Notes.	
	→ pt takenover from Evening duty staff, pt conscious & oriented, pt Vitals i/c HR - 54/mt SPO2 - 95%, BP - 123/81 mmHg Checked & Reported	DRHO
20:00	→ pt had (A) diet	
	→ medicine given as per drug chart	DSHO
	→ pt IVF NS - 30cc/hr on flow	
24:00	→ pt Provided comfort position	DSHO
2:00	→ pt hourly I/O chart monitoring.	DSHO
4:00	→ pt Inves - Urea, creatine sample send to the lab.	DSHO
5:00	→ pt FCCY taken, CBG checked & Reported,	DSHO
6:00	→ pt morning care to be done	DSHO
6:30	→ pt T. pan 40mg given as per drug Chart.	
7:00	→ pt handingover to morning duty staff	DSHO

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jayadevi	Jayadevi	0002	2/1/24	10:00

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 3/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: CAD-AWMI / LYSED C STK (1/23) GCS: 15/15
NEWS./ PEWS Score: — POD:
Ventilator day: — Central line days: —
Peripheral line day: Right: Brachial Left: Brachial
Ryle's Tube: ☐ Yes ☑ ~~No~~ Day: VIP Score: 0/5
Urinary Catheter: ☐ Yes ☑ ~~No~~ Day:
Barrier nursing: ☐ Yes ☑ ~~No~~ MDR: ☐ Yes ☑ ~~No~~. If Yes, specify organism:

B — BACKGROUND

Type of surgery: PTCA TO LAD MAJOR. DIAGONAL + IVUS GUIDANCE. Date of surgery: 2/1/24.
Allergies if any: NKDA.
On room air / oxygen: Room Air IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 54 (beats/min) | Respiration: 18 (breaths/min)
BP: 110/77(86) (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 61.6 (kgs) | BMI: 21.8 kg/m²
Others: —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 35 **Fall Risk Protocol:** ☑ ~~Low~~ ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ ~~NA~~ Wound Dressing done: ☐ Yes ☐ No ☑ ~~NA~~
Current diet: Normal diet Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
} NIL

Changes in nursing care plan: ☐ Yes ☑ ~~No~~. If Yes, modified care plan date: _____
Pending follow-up orders:
Special instructions if any:
} NIL

	Signature	Name	Emp. No.	Date	Time
Handover given by	S P Sree	gs. Premalatha	0211	3/1/24	10.45
Handover taken by	S	Jaya Lucy	0118	3/1/24	10.45
Document endorsed	Jayasree	Jayasree	0002	3/1/24	10.45

MHI/NUR/2022/048

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
3/2/24 @	Morning Duty Notes	
7:30	⇒ Pt taken over from night duty staff. Pt is consious & oriented. Pt heamodynamically stable & recorded.	0211
7:40	⇒ Pt yesterday PTCA to LAD & IVUS guided done. Rt radial approach no oozing & heamatoma.	0211
7:50	⇒ Pt had diet no other complaints	
8.00	⇒ Pt medication given as per drug chart	0211
9:00	⇒ Pt hourly I/O chart maintained & recorded.	0211.
9:30	⇒ Pt G.Namdeu Sir seen the Pt. Shifted to ward. & Pressure bandage removed.	0211
10:00	⇒ Pressure bandage removed no oozing & heamatoma.	
	⇒ Pt shifted to ward IInd floor. General ward. Pt file, reports hand over to IInd floor staff.	0211.
	Receiving Notes	
10:35	pt received from cw at 10:45	[illegible]
	pt cousious & oriented	
	pt lied on normal diet	
	medication administration as per drug chart.	[illegible]
	vitals [illegible] [illegible]	
12.00	pt handing over to the Evening duty	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	[signature] 0002	Jayadevi	0002	3/1/24	10:00

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Dr.G. GNANAVELU

MHI/NUR/2022/048

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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 2/1/24 Shift: ☐ Morning ☑ Evening ☐ Night

S — SITUATION

Diagnosis: CAD - AWMI / LYSED C STK (12/23) GCS: 15/15
NEWS / PEWS Score: — POD: —
Ventilator day: — Central line days: —
Peripheral line day: Right: Brachial Left: Brachial
Ryle's Tube: ☐ Yes ☑ No Day:
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☑ No MDR: ☐ Yes ☑ No. If Yes, specify organism:
VIP Score: 0/5

B — BACKGROUND

Type of surgery: PTCA TO LAD Date of surgery: 2/1/24
Allergies if any: NKDA
On room air / oxygen: Room air IV fluids on flow: —
Complaints / New Symptoms in last shift: —

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 84 (beats/min) | Respiration: 18 (breaths/min)
BP: 110/70 (mmHg) | SpO_2: 96 (%) | Height: 168 (cms) | Weight: 61.6 (kgs) | BMI: 21.8 kg/m²
Others : —
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: _____ **Fall Risk Protocol:** ☑ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ NA Wound Dressing done: ☐ Yes ☐ No ☑ NA
Current diet: Normal diet. Drains: —

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
} Nil
Changes in nursing care plan: ☐ Yes ☑ No. If Yes, modified care plan date: —
Pending follow-up orders:
Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by		Jeni Priya.	0284	31/1/23	14:00
Handover taken by		A. ALBINUS	0088	31/1/23	19:00
Document endorsed		C. Nalini	0084	31/1/24	20:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
3/1/24	EVENING DUTY NOTES	
12.30		
	=> Pt handing over taken from night Morning duty staff.	
	=> Pt conscious and orientation.	
14.00	=> Pt vitals checked and recorded.	
	=> Pt due drugs are given as per drug chart.	
15:30	=> Pt Mobilized well.	
	=> Pt vitals checked	
16.00	=> Nebulization was given to the patient.	
18.00	=> Administered the Medication	
	=> Pt had Normal diet.	
19.20	=> Pt I/O chart Monitered	
	=> Pt handing over to night duty staff.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0084	3/1/24	20:0

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NABH ACCREDITED

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 3/1/24 Shift: ☐ Morning ☐ Evening ☑ ~~Night~~

S — SITUATION

Diagnosis: CAD - AWMI / LVSCD & STK GCS: 15/15
NEWS / PEWS Score: 0 POD: —
Ventilator day: — Central line days: —
Peripheral line day: Right: BRACHIAL Left: —
Ryle's Tube: ☐ Yes ☑ ~~No~~ Day: —
Urinary Catheter: ☐ Yes ☑ ~~No~~ Day: VIP Score: 0/5
Barrier nursing: ☐ Yes ☑ ~~No~~ MDR: ☐ Yes ☑ ~~No~~ If Yes, specify organism:

B — BACKGROUND

Type of surgery: — Date of surgery: 2/1/24
Allergies if any: NKDA
On room air / oxygen: ON ROOM AIR IV fluids on flow: —
Complaints / New Symptoms in last shift:

A — ASSESSMENT

Vital Signs: Temp: 98 (°F) | Pulse / HR: 80 (beats/min) | Respiration: 22 (breaths/min)
BP: 130/90 (mmHg) | SpO_2: 97 (%) | Height: 168 (cms) | Weight: 61.6 (kgs) | BMI: 21.8 Kg/m²
Others : NIL
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 0 **Fall Risk Protocol:** ☑ Low ☐ Medium ☐ High
Braden Score: ☐ Minimal Risk: 23-19 ☑ ~~At Risk-Mild Risk: 18-15~~ ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☑ ~~No~~ ☐ NA Wound Dressing done: ☐ Yes ☑ ~~No~~ ☐ NA
Current diet: NORMAL diet Drains: —

R — RECOMMENDATION

Referral doctors: —
Pending medications: —
Pending medication indent: —
Pending lab reports / Investigations: —
Critical value alert and its corrections: —
Changes in nursing care plan: ☐ Yes ☑ ~~No~~ If Yes, modified care plan date: _____
Pending follow-up orders: —
Special instructions if any: —

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. ALBINUS	0080	4/1/24	7.00
Handover taken by		Agastees	0116	4/1/24	7.40
Document endorsed		S. Nalini	0024	4/1/24	8.00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
3/1/24	NIGHT DUTY NOTES	
19:00	Patient handovers taken from the evening duty staff. Patient is stable	0084
20:00	Due medications are given to the patient	0084
22:00	Vitalsigns are checked & recorded	0084
6:00	I/o chart is maintained.	0084
7:00	Patient handovers given to the morning duty staff.	0084

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		S. Nalini	0084	4/1/24	8:00

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/OPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/048

Medway Heart Institute
Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 4/1/24 Shift: ☑ Morning ☐ Evening ☐ Night

S — SITUATION

Diagnosis: CAD – AVRD GCS: 15/15
NEWS / PEWS Score: 0 POD: –
Ventilator day: – Central line days: –
Peripheral line day: Right: Popliteal Dg. Left:
Ryle's Tube: ☐ Yes ☑ No Day: VIP Score: 0/1
Urinary Catheter: ☐ Yes ☑ No Day:
Barrier nursing: ☐ Yes ☐ No MDR: ☐ Yes ☐ No. If Yes, specify organism:

B — BACKGROUND

Type of surgery: NOLDA Date of surgery: –
Allergies if any: on room air
On room air / oxygen: IV fluids on flow: –
Complaints / New Symptoms in last shift: –

A — ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 76 (beats/min) | Respiration: 22 (breaths/min)
BP: 100 70 (mmHg) | SpO_2: 96 (%) | Height: 160 (cms) | Weight: 61.6 (kgs) | BMI: 24.3 kg/m²
Others : –
Pain Score: 0/10 **Pain Scale used:** PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / ~~NRS~~ / CPOT
Fall Risk Score: 30 **Fall Risk Protocol:** ☐ Low ☐ Medium ☑ ~~High~~
Braden Score: ☑ ~~Minimal Risk: 23-19~~ ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☑ ~~NA~~ Wound Dressing done: ☐ Yes ☐ No ☑ ~~NA~~
Current diet: Normal diet Drains: Nil

R — RECOMMENDATION

Referral doctors:
Pending medications:
Pending medication indent: Nil
Pending lab reports / Investigations:
Critical value alert and its corrections:
Changes in nursing care plan: ☐ Yes ☑ ~~No~~. If Yes, modified care plan date: –
Pending follow-up orders:
Special instructions if any: Plan today discharge

	Signature	Name	Emp. No.	Date	Time
Handover given by		Jayalakshmi	0110	4/1/24	12:30
Handover taken by	S. D.	S. Dewadharshini	0212	4/1/24	12:30
Document endorsed		S. Nalini	0084	4/1/24	13:00

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	Morning duty Notes	
4/1/24 7.50	Pt taking over from the Night duty staff Pt conscious & oriented	Sw
8.45	Pt cod on regular diet medication administration as per chart. Pt c/o no complaints today plan discharge.	Sw
10.00	Pt cod no complaints. Pt vitals monitored Vital Sign cked & monitored Dr chart monitored	
11.30	Pt handing over to the evening duty staff	Sw
12.00	Discharge Note	
4/1/24	⇒ Pt Discharge today plan. ⇒ Pt conscious & Oriented. ⇒ Pt ID Band removed ⇒ Pt IV line removed.	S.D. 6/1.
18.00	⇒ Pt handing over given to Pt & Pt attender.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Nal	S. Nalini	0084	4/1/24	2.00

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ADULT NURSING CARE PLAN

Patient Details
Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 2/1/24 **Time:** 13.00 | **Modified Date:** **Time:**

Reason for Modification: | **Diagnosis:** CAD- AWMI

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☑ Keep NPO ☐ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt NPO from 9AM E Pt on (N) diet N Pt on (N) diet	ODS ODS
OXYGENATION ☑ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt is on room air E Pt on room air N Pt on Room air	ODS ODS
FLUID & ELECTROLYTES ☑ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☑ Patient will have balanced fluid and electrolytes balance	☑ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M I/O Chart monitoring E If UP N > 30 ml/hr N IVF NS - 30 cc/hr on flow	ODS ODS

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☑ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☑ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt good mobilized E Pt motivated to bed freely N Pt on bed mobilization	
ELIMINATION ☑ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☑ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☑ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt Self voiding E Pt on (N) elimination pattern N Pt on self voiding	
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☑ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Maintain normal skin intact E Pt maintain (N) skin integrity N maintain (N) skin integrity	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt good hygiene E pt stay clean & well groomed N Pt well groomed	
SAFETY ☐ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M ID Band weard E ID band N Pt ID band	
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M Provide comfortable position E Pt on compose position N Pt on comfort position	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Vital signs checked & recorded E hrly V/s checked N Hourly vitals monitored	
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M Provide Psychological support E Psychological support given N Psychological support to pt	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt good communication E Pt on good communication N Pt good communication	
SPECIAL INTERVENTIONS ☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products *transfusion* ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure *compatibility* ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M — E Administered medicine as per drug chart N medicine given as per drug chart	

	Signature	Name	Emp. ID	Date	Time
Endorsed by		Nalini	0024	08/01/24	14.30

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NABH ACCREDITED

ADULT NURSING CARE PLAN

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 3/1/24	**Time:** 8:00	**Modified Date:**	**Time:**	
Reason for Modification:		**Diagnosis:** CAD - AWMI		

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☑ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☑ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt had. Normal diet	[signature]
			E pt had Normal diet.	[signature]
			N Pt had NORMAL diet	[signature]
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☑ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☑ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on Room AIR. SPO_2 - 99%	[signature]
			E Pt on Room air	[signature]
			N SPO_2 - 95%	[signature]
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Pt take oral well	[signature]
			E Pt I/O chart Monitored.	[signature]
			N Pt I/O chart Monitored	[signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt mobilized well E Pt mobilized well. N Pt Mobilized well	OLH Jen on. dy 0085
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Pt (N) elimination Pattern E Pt (N) elimination Pattern. N Pt (N) elimination Pattern	OLH Jen on. dy 0085
SKIN INTEGRITY ☑ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☑ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M Pt maintain (N) skin integrity E Pt maintain (N) skin integrity. N Skin is intact	OLH. Jen on. dy 0085

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☑ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☑ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt clean & well groomed E pt clean & groomed well N Pt clean & groomed well	 Jen od86
SAFETY ☑ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☑ Patient will have no life-threatening situations	☑ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M Pt ID band Present E pt ID band present. N ID Band (+)	 Jen od86
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☑ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☑ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M Pt Provide Comfortable Position E pt provide Comfortable Position N Pt Provide Comfortable Position	 Jen od86
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☑ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M Pt VS checked & recorded E pt Vitals checked. N Pt vitals is checked	 Jen od86
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☑ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☑ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M Pt Provide Psychological Support E Pt provide Psychological support N Psychological Support given	 Jen od86

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☑ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☐ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt Communication well E Pt communication well N Pt Communication well	0211 Jem 0085
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☐ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M Pt medication given as per drug chart E Pt Medication given as per drugchart. N Due drugs are given	0211 Jem 0085

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Jay 0002	Jayadevi	0002	3/1/23	10:00

Medway Hospitals®
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(A Unit of United Alliance Healthcare Pvt Ltd)

ADULT NURSING CARE PLAN

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/044

Medway Heart Institute
Every heart beat counts

Initial Date: 4/1/24	Time: 7.00	Modified Date:	Time:
Reason for Modification:		Diagnosis: CAD - AWMI	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	☐ Provide Prescribed diet on time ☐ Encourage patient to consume the served meal ☐ Record amount of food consumed	M Pt tol on Normal diet E N	Sub
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O_2 ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	☐ Patient will have normal O_2 saturation ☐ Patient ABG levels will return to and remain within normal limits ☐ No other respiratory abnormalities ☐ Patient respiratory rate will remains within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O_2 saturation and pulse rate ☐ If any O_2 abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness ☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Pt on room air E N	Sub
FLUID & ELECTROLYTES ☐ Oral ☐ Intravenous ☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:	☐ Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Monitored Iv Chart E N	Sub

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Patient will use safety measures to minimize potential for injury ☐ Patient will demonstrate the use of adaptive devices to increase mobility	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M pt awael mobilized E N	Sub
ELIMINATION ☐ Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Bowel movement ☐ Urination ☐ Others:	☐ Patient will have normal elimination pattern ☐ Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M pt self voiding E N	Sub
SKIN INTEGRITY ☐ Maintain normal skin integrity ☐ Pressure points site assessment ☐ HAPI ☐ OPI **GRADES OF PRESSURE INJURY** ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	☐ Minimize / Eliminate friction and shear ☐ Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces and devices ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin ☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing ☐ Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Educate patient and family members about further skin care	M maintained Normal skin E N	Sub

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care (if present) ☐ Others:	☐ Patient will stay clean and well-groomed ☐ Patient will demonstrate lifestyle changes to meet self-care needs ☐ Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Pt well groomed E N	
SAFETY ☐ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:	☐ Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	M checked ID band E N	
COMFORT AND SLEEP ☐ Pain Control ☐ Sleep Patterns ☐ Others:	☐ Patient will have comfortable sleep ☐ Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M provided comfortable position E N	
OBSERVATION ☐ Vital Signs ☑ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	☑ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	M monitored vital sign E N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT ☐ Spiritual Needs ☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	☐ Patient will achieve spiritual needs ☐ Patient will be able to control his feeling toward his illness ☐ Patient will maintain normal psychological pattern	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance	M E N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	☑ Patient will communicate effectively with positive feedback	☑ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence	M Pt well communication E N	Sus
SPECIAL INTERVENTIONS ☑ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:	☐ To manage on time	☑ Double check for high alert medication ☐ Observe and report any medication reaction ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids ☐ Monitor DVT score and continue treatment as per doctors order	M due drug given E N	Sus

	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nalini	S. Nalini	0084	4/1/24	13:0

Medway Hospitals®
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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 2	1	24
					Time: M	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	3	3
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	1	1
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	3	3
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	3	3
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	3
				TOTAL SCORE	23	17	17
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

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Patient Details (Affix Label here)
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48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 3	1	2A
					Time: 5M	E	D
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	A
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	4
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	4
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	2	2	4
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3	A
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				TOTAL SCORE	17	17	23
				Initial & Emp. No. of Staff Nurse:			
				Initial & Emp. No. of Sr. Staff Nurse:			

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

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NABH

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Dr.G. GNANAVELU

MHI/NUR/2022/045

Medway Heart Institute
Every heart beat counts

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 4 / 1 / 24		
					Time: 19 / 6 / AM		
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	3		
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3		
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	3		
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3		
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3		
				TOTAL SCORE	19		
				Initial & Emp. No. of Staff Nurse:			
Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*				**Initial & Emp. No. of Sr. Staff Nurse:**			

S.No. : 22

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Dr.G. GNANAVELU

MHI/NUR/2022/052

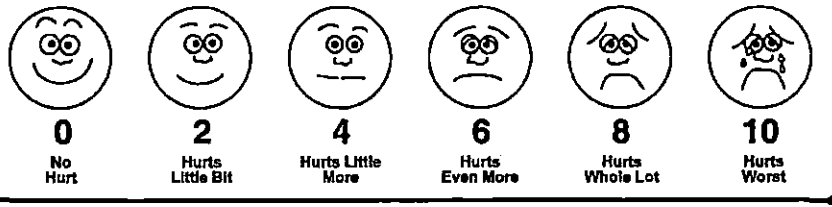
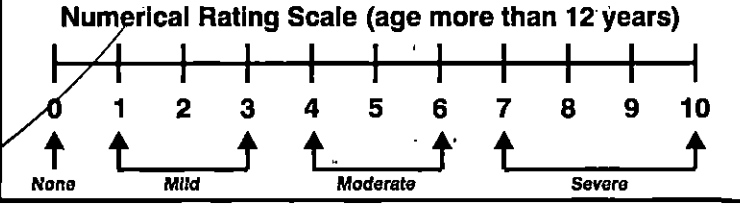
Medway Heart Institute
Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
21/1/24 13:00	0/10	NO Pain	—	—	—	0025	Q4
		P7 received from cath lab @ 17:00					
17:00	0/10	NO pain	—	—	—	0025	
18:00	0/10	NO pain	—	—	—	0025	
19:00	0/10	NO pain	—	—	—	0025	
20:00	0/10	No pain	—	—	—	0240	
21:00	0/10	No pain	—	—	—	0240	
22:00	0/10	No Pain	—	—	—	0240	
23:00	0/10	No Pain	—	—	—	0240	

Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
23/11/24 00:00	0/10	No pain	—	—	—	6240	Jaya Moor
1:00	0/10	No pain	—	—	—	6240	Jaya Moor
2:00	0/10	No Pain	—	—	—	6240	Jaya Moor
3:00	0/10	No pain	—	—	—	6240	Jaya Moor

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
3/1/24 4:00	0/10	No pain	—	—	—	0240	Jay 0002
5:00	0/10	No pain	—	—	—	0240	Jay 0002
6:00	0/10	No pain	—	—	—	0240	Jay 0002
7:00	0/10	No pain	—	—	—	0240	Jay 0002
8:00	0/10	No Pain	—	—	—	0241	Jay 0002
9:00	0/10	No Pain	—	—	—	0241	Jay 0002
10:00	0/10	No Pain	—	—	—	0241	Jay 0002
12:00	0/10	No pain	—	—	—	Jem 0241	Nur 0024
18.00	0/10	NO Pain	—	—	—	Jem 0241	Nur 0024

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
22:00	0/10	No Pain	–	–	–	0085	024
4/12/24 2:00	0/10	No Pain	–	–	–	0085	024
6:00	0/10	No Pain	–	–	–	0085	024
10:00	0/10	no pain	–		–	0046	024

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
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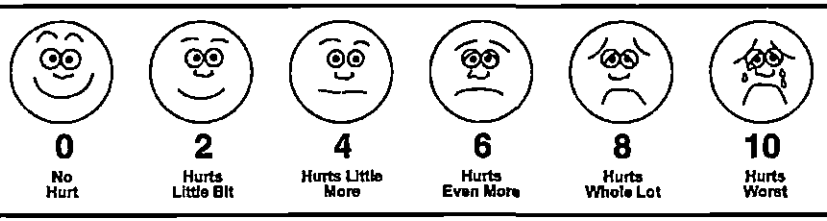
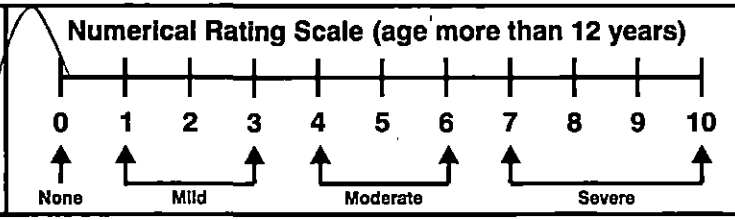
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling
Pharmacological Interventions as per doctor's prescription	

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MHI/NUR/2022/047

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DVT RISK ASSESSMENT

Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

S. No.	PARAMETERS							
	Date	2/1/24	3/1/24	4/1/24				
	Time	13.00	8:00	6.00				
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0				
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0				
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0				
5	Entire leg swollen (Assess for both legs)	0	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0				
9	Previously documented DVT (Assess for both legs)	0	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0				
	FINAL SCORE	0	0	0				
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8	Low	Low	Low				
	DVT prophylaxis started	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN							
	Signature & Emp. No. of Sr. RN							

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NABH ACCREDITED

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH202400001
Dr.G. GNANAVELU

Medway Heart Institute
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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables		Date	2/1/24	2/1/24	2/1/24	3/1/24	3/1/24	3/1/24	4/1/24		
		Time	13:00	18:00	20:00	8:00	14:00	22:00	2:00		
History of falling *(immediate or within 6 months)*	No		0	0	0	0	0	0	0	0	0
	Yes		25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No		0	0	0	0	0	0	0	0	0
	Yes		20	20	20	20	20	20	20	20	20
AMBULATORY AID None / Bed Rest / Nurse Assist			0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker			15	15	15	15	15	15	15	15	15
Furniture			30	30	30	30	30	30	30	30	30
GAIT Normal / Bed Rest / Wheel Chair			0	0	0	0	0	0	0	0	0
Weak			10	10	10	10	10	10	10	10	10
Impaired			20	20	20	20	20	20	20	20	20
MENTAL STATUS Oriented to own stability			0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations			15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No		0	0	0	0	0	0	0	0	0
	Yes		15	15	15	15	15	15	15	15	15
Total Score			35	33	35	35	35	35	35		
Low Risk (0 - 24)											
Medium Risk (25 - 44)			✓	✓	✓	✓	✓	✓	✓		
High Risk (45 or above)											
Signature & Emp. No. of RN											
Signature & Emp. No. of Sr. RN											

0 - 24: Low Risk; 25 - 44: Medium Risk; 45 or above: High Risk

INTERVENTIONS *Tick as per the Risk Score*	Date	2/1/24	2/1/24	2/1/24	3/1/24	3/1/24	3/1/24	4/1/24		
	Time	13.00	16:00	20:00	8:00	14:00	22:00	2:00		
Low Risk Interventions (0 - 24)		✓	✓	✓	✓	✓	✓	✓		
Familiarize the patient with the immediate surroundings		✓	✓	✓	✓	✓	✓	✓		
Remind the patient to use call bell before getting out of bed		✓	✓	✓	✓	✓	✓	✓		
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓	✓	✓	✓	✓	✓		
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓	✓	✓	✓	✓	✓		
Remove excess equipment or furniture to make a clear path		✓	✓	✓	✓	✓	✓	✓		
Keep the patient's bed in the low position at all times except during procedure		✓	✓	✓	✓	✓	✓	✓		
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓	✓	✓	✓	✓	✓		
Bed wheels should be locked		✓	✓	✓	✓	✓	✓	✓		
Encourage family participation in the patient's care		✓	✓	✓	✓	✓	✓	✓		
Ensure that floor of the bathroom is dry and not slippery		✓	✓	✓	✓	✓	✓	✓		
Review medications for potential side effects that can promote falls		✓	✓	✓	✓	✓	✓	✓		
Use safety belts during movement in wheelchair		✓	✓	✓	✓	✓	✓	✓		
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓	✓	✓	✓	✓	✓		
Medium risk interventions (25 - 44)										
Apply all the low risk interventions		✓	✓	✓	✓	✓	✓	✓		
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher		✓	✓	✓	✓	✓	✓	✓		
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat		✓	✓	✓	✓	✓	✓	✓		
Use restraints and bed monitors as ordered by the doctor		✓	✓	✓	✓	✓	✓	✓		
Allow the patient to ambulate only with assistance		✓	✓	✓	✓	✓	✓	✓		
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care		✓	✓	✓	✓	✓	✓	✓		
Do not leave patients unattended in diagnostic or treatment areas		✓	✓	✓	✓	✓	✓	✓		
Accompany the patient while going to bathroom		✓	✓	✓	✓	✓	✓	✓		
Advice the patient to use grab bars near the toilet, bathtub, and shower		✓	✓	✓	✓	✓	✓	✓		
Make sure the family and other visitors understand the restrictions mentioned above		✓	✓	✓	✓	✓	✓	✓		
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions										
Tie red fall risk tag in the bed, wheel chair and stretcher										
Locate the high-risk patients in a room close to the nurses' station										
Answer these patients call bells as quickly as possible										
Provide a commode at bedside (if appropriate)										
Urinal/bedpan should be within easy reach (if appropriate)										
Encourage family members or other visitors to stay with them										
If appropriate, consider using protection devices: safety belts										
Signature & Emp. No. of RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
Signature & Emp. No. of Sr. RN		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IP/2022/055

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PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☑ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☑ Simple Language
☐ Congnitive Limitations - unable to understand and follow directions	☐ Low motivation / desire to learn	☐ Written Instuctions
Completed By : Date 2/1/24 Time 13.00		Nurse Signature :

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	2/1/24	L	P	O	3/1/24	L	P	O	4/1/24	L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics		P	OD	V		P	OD	V		P	OD	V	
☑ Treatment													
Medications		P	OD	V		P	OD	V		P	OD	V	Doctor / Nurse
☑ Information on Safe and Effective use of medicines		P	OD	V		P	OD	V					
☑ Information on drug / drug and drug / food interactions		P	OD	V		P	OD	V		P	OD	V	
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☐ Post - Operative Instructions (Wound / Dressing Care)													
Pain Management													Nurse
☑ Reporting of pain		P	OD	V		P	OD	V		P	OD	V	
☑ Pain Management		P	OD	V		P	OD	V		P	OD	V	
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☐ Diet Instruction for patients at Nutritional risk			new				new				new		
☐ Diet advice for home											new		Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other_____(State Relationship)

PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material

OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding

Written Material given and explained (if any)

Reports Given :

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	✓			Diet Advice	✓		
ECG Report	✓			CT Scan Report			
Doppler Report				CT Scan Film			
X-Ray Report				ECHO Report	✓		
X-Ray Film	✓			Ultrasound Report			
Compact Disk				Any Other Report	✓		

Name of Attendant / Patient : G. Selvi Signature : G Selvi

Name of Discharge Nurse A. Nandhini Signature :

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NABH

Patie Mr.SRIDHARAN S
Nam 53Yrs / M/MH2212333
UHID 10/10/2023/IPH202301994
DOB Consultant :ANBARASU MOHANRAJ
DOA
Cont

MHI/IP/2022/055

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PATIENT AND FAMILY EDUCATION RECORD

Assessment To be filled by concerned disciplines. Use key below

Barriers to Learning		Plan to Address Factors
☑ None	☐ Vision / Hearing limitations	☐ Use of Interpreter
☐ Limited Reading Abilities	☐ Physical barriers	☐ Educate family
☐ Religious / Cultural Factors	☐ Language barriers	☐ Simple Language
☐ Congnitive Limitations - unable to	☐ Low motivation / desire to learn	☐ Written Instuctions
understand and follow directions		

Completed By : Date 12/10/23 Time 5-00 Nurse Signature :

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
	15/10/23	L	P	O	15/10/23	L	P	O	16/10/23	L	P	O	
Disease													Doctor
☑ Information on Disease / Diagnostics		P	OD	V		P	OD	V		P	OD	V	
☑ Treatment		P	OD	V		P	OD	V		P	OD	V	
Medications													Doctor / Nurse
☐ Information on Safe and Effective use of medicines													
☐ Information on drug / drug and drug / food interactions													
☐ Discharge Medications													
Surgical Instructions													Nurse
☐ Pre - Operative Instructions													
☑ Post - Operative Instructions (Wound / Dressing Care)		P	OD	V		P	OD	V		P	OD	V	
Pain Management													Nurse
☑ Reporting of pain		P	OD	V		P	OD	V		P	OD	V	
☑ Pain Management		P	OD	V		P	OD	V		P	OD	V	
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment Rehabilitation Techniques													

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
☑ Diet Instruction for patients at Nutritional risk		P	on	V		–	–	–		P	on	V	Maria Catherine John Senior Dietitian
☑ Diet advice for home		–	–			–	–	–		P	on	V	Nurse
Discharge Planning													
☐ Self care													
☐ Follow up													
☐ Reporting Concerns Immunizations													
☐ Parenting education													
☐ Others													
Risk Factor Reduction													
☐ Smoking Cessation													Doctor
☐ Weight Control													
☐ Exercise													
☐ Hypertension													
☐ Other Risks													

LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other_____(State Relationship)

PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material

OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding

Written Material given and explained (if any)

Reports Given :

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	✓			Diet Advice	✓		
ECG Report	✓			CT Scan Report			✓
r Report			✓	CT Scan Film			✓
			✓	ECHO Report	✓		
	✓			Ultrasound Report			✓
			✓	Any Other Report			✓

t : S. JANANI Signature : S. Janani

E. Cathy Signature : E. Catherine

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH202400001
Dr.G. GNANAVELU

MHI/IP/2022/054

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IN-HOUSE TRANSFER FORM

Part A *(to be filled by Nurses)*

Date of Transfer: 3/1/24 Time: 10:25 Transferred from: CCU To: IInd floor (4-W)

Diagnosis: CAD - 1 Arms - S/P Lysed & 2-STK (12/23). Mod-LVSD.

Vital Signs: Temp: 98° (°F) | Pulse / HR: 62. (beats/min) | BP: 114/70 (mmHg) | Respiration: 20. (breaths/min)

Part B *(to be filled by Physicians)*

Any Critical Investigations: _____

Check for	Transferring Doctor	Receiving Doctor
Respiratory (Breath sounds)	☑ Clear ☐ Crepitation ☐ Rhonchi ☐ Others: _____	☑ Yes ☐ No
Abdomen	☑ Soft ☐ Tender ☐ Distended ☐ Others: _____	☑ Yes ☐ No
Heart Sound	☑ Normal ☐ Feeble ☐ Loud ☐ Others: _____	☑ Yes ☐ No
CNS	☑ Conscious ☑ Oriented GCS Score: 15/15	☑ Yes ☐ No
For Surgical Patients (if applicable)	Surgical Site: ☐ Healthy ☐ Soakage ☐ Others: _____	☑ Yes ☐ No

Present Medication *(for Medication Reconciliation)*

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1)	T-ASA	75mg	P/O	OPD	2/1/24 @ 16:00	☑ Yes ☐ No
2)	T-AXCER	90mg	P/O	1-0-1	31/1/24 @ 8:30	☑ Yes ☐ No
3)	T-ATORVA	40mg	P/O	0-0-1	2/1/24 @ 20:00	☐ Yes ☐ No
4)	T-MET-XL	25mg	P/O	1-0-1	31/1/24 @ 8:30	☑ Yes ☐ No
5)	T-FLAVEDON-MR	35mg	P/O	1-0-0	31/1/24 @ 8:30	☐ Yes ☐ No
6)	T-NITROCONTIN	2.6mg	P/O	1-0-1	31/1/24 @ 8:30	☐ Yes ☐ No
7)	T-PAN	40mg	P/O	1-0-1	31/1/24 @ 8:30	☑ Yes ☐ No
8)	T-ALPRAX	0.25mg	P/O	0-0-1	2/1/24 @ 20:00	☑ Yes ☐ No
9)	T-ISDN	5mg	S/L	PRN		☑ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Additional Details *(if any)*:

Patient Condition: ☐ Stable ☐ Sick-need urgent care ☐ Others: _____

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		Dr. K. Anusya	91810	31/24	10:25
Receiving Doctor		Dr. K. Anusya	134559	31/24	10:35

Part C *(to be filled by Nurses)*

Check for	Transferring Nurse	Receiving Nurse
Drains	☐ Chest ☐ Abdominal ☑ Others: _____	☑ Yes ☐ No
Respiratory	Air Way Type: ☐ Patent ☐ Tracheostomy ☑ Others: _____ Oxygen Therapy: ☑ No ☐ Yes via: _____ Rate: _____ li/min	☑ Yes ☐ No
NG Tube / Oral	☐ Yes ☑ No ☐ For Feeding ☐ Gastric Suction ☐ Fluid Restriction	☑ Yes ☐ No
Foley's Catheter	☐ Yes ☑ No	☑ Yes ☐ No
Intravenous Access	☑ Peripheral Line ☐ Central Venous Line ☐ Others: _____	☑ Yes ☐ No
Pressure Injury	☐ Yes ☑ No If Yes, give details: _____	☑ Yes ☐ No
Score	Fall Risk: 25 WELLS: NEWS / PEWS:	☑ Yes ☐ No
Patient Belongings	☐ Yes ☑ No If Yes, give details: _____	☑ Yes ☐ No
Handover Details	Medication Administration Record explained: ☑ Yes ☐ No Lab & Diagnostic Reports handed over: ☑ Yes ☐ No	☑ Yes ☐ No
Patient Attendant *Informed*	☑ Yes ☐ No If No, give details: _____	☑ Yes ☐ No

Additional Details *(if any)*:

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse		S. Premalatha	021	31/24	10:25
Receiving Nurse		Agastya	016	31/24	10:35

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Patient Details (Affix Label here)
Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MHI/IP/2022/051

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FAMILY COUNSELLING F...

CONSULTANT- CAD - Awm, - Lysed & STK | DIAGNOSIS- DR Gnanavelu.

DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
2/1/24	Doctor	wife.	Family updated.		G Sabi	Dr Gnanavelu 9514
3/1/24	Doctor	WIFE.	Pt Condition updated to family		G Sabi	9/1/24.

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VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011

IP No. / UHID No

AGE / SEX : Dr.G. GNANAVELU

Ward / Bed No.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
	13.						
2/1/24	13.00	RT Brachial	0/5	Patent	flushed	followed	
	20:00	RT Brachial	0/5	patent	flushed	followed	
3/1/24	8.00	RT Brachial	0/5	Patent	Flushed	Followed	
		RT Brachial		line removed.			
2/1/24	13.00	LT Brachial	0/5	Patent	flushed	followed	
	20:00	LT Brachial	0/5	patent	flushed	followed	
3/1/24	8.00	LT Brachial	0/5	Patent	Flushed	Followed	
	14:00	LT Brachial	0/5	Patent.	Flushed	followed	
	22.00	LT BRACHIAL	0/5	Patent	flushed	followed	
4/1/24	8.00	LT Brachial	0/5	patent	flushed	followed	
		IV line Removed					

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

TCA Pathway Checklist

FORM/PATH/PTCA/05

Patient Name: MR.GOPINATH.R. Age/Sex: 48 yrs/Male.

I.D. no: MHI202381395 Date of Admission: 2/1/24.

Allergies: NKDA..... Not Known..... None Height: 168cm Weight: 61.6kg.

Day 1	Pre-Operative Order Sheet	Status	Cause of Variation(if any)	Remarks
Location	IP UNIT	✓		
Assessment/ Documentation	History taken	✓		
	Procedure /Anesthesia consent taken	✓		
	Pre-Op Checklist	✓		
Observation	Monitor vitals	✓		
Investigations	Pre-Cath Profile as per protocol	✓		
	Echo Screening	✓		
	ECG	✓		
Nutrition	Keep NPO 4 hours before procedure	✓		
Medications	Review Current Medications	✓		
	Pre-Op Medications as advised (Aspirin 300mg & Clopidogrel -600 mg to be given)			
	IV Fluids as advised	✓		
Blood Availability	Arrange for Blood if required			
Education : Patients / Relatives	Pre-op Teaching	✓		
ıecial Need identification	Home care needs assessed :			
Discharge Planning	Explanation of Discharge Plan			

Additional Information :

Name & Signature of Doctor:.....

Name & Signature of Nurse:.....

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PTCA Pathway Checklist

Day 2	Post Operative Order Sheet	Status	Cause of Variation(if any)	Remarks
Location	IP Unit	✓		
Observation	Monitor vitals	✓		
	Monitor pain Score	✓		
Assessment/ Documentation	Cath Flow Sheet filled			
Medication	Medication as advised	✓		
Treatment	Wound Care and Dressing	✓		
Nutrition	As Advised by dietician	✓		
Investigations	Echo Screening	✓		
	ECG	✓		
Education: Patient's/Relative	Ward Education	✓		
Special Need Identification	Any other advice or need as required			
Discharge Planning	Fit for Discharge			
	Prepare Discharge Summary			

Additional Information:

Name & Signature of Doctor: Dr. [illegible] 9/8/10

Name & Signature of Nurse:.....

MHI/PHARM/2022/028

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MEDICATION ADMINISTRATION RECORD

Drug Chart: 1 of 1 Height (cms): 168cm Weight (kg): 61.6kg

KNOWN MEDICINE ALLERGIES *(if NONE is confirmed, write NKDA in box 1)*

Drug Details	Description of Allergy	Doctor's Sign:
	NOT KNOWN	Name: Dr. B. Sujith Reg. No. 183573

DOCTOR INSTRUCTIONS	NURSING STAFF INSTRUCTIONS
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time	1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings 4. Standard Timings: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
2/1/24	14.40	INJ: FENTANYL *	25mcg	IV		97211		0176 0016	14.40
2/1/24	14.40	INJ: EMESET	4mg	IV		97211		0176	14.40
2/1/24	14.45	INJ: NTG *	200mcg	IA		97211		0176 0016	14.45
2/1/24	14.47	INJ: HEPARIN *	5000 IU	IA		97211		0176 0016	14.45
2/1/24	15.00	INJ: HEPARIN *	2500 IU	IV		97211		0176 0016	15.00
2/1/24	15.48	INJ: HEPARIN *	2000 IU	IV		97211		0176 0016	15.48
2/1/24	16.10	INJ: TIROFIBAN *	10ML BOLUS	IV		97211		0176 0016	16.10
2/1/24	16.40	INJ: HEPARIN *	1000 IU	IV		97211		0176 0016	16.40

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

Date → To be filled by Nursing Staff only. Sign and time given

Time ↓ | 2/1/24 | 3/1/24 | 4/1/24

DRUG NAME TAB. ASA

Dose	Route	Frequency
Fasting	oral	0-1-0

Dr. Sign & Reg. No. / Seal: RB 183873
Start Date & Time: 2/1/24 @ 13:00
Stop Date & Time:
Additional Info:

Time 14:00 — 2/1/24: → ; 3/1/24: 14:20 (signed); 4/1/24: 14:00 (signed)

Clinical Pharmacist Medway Heart Institute

DRUG NAME T-AACER

Dose	Route	Frequency
90mg	oral	1-0-1

Dr. Sign & Reg. No. / Seal: RB 183873
Start Date & Time: 2/1/24 @ 13:00
Stop Date & Time:
Additional Info:

Time 8:00 — 2/1/24: → ; 3/1/24: 8:30 (signed); 4/1/24: 8:45 (signed)
Time 20:00 — 2/1/24: (signed) 0024; 3/1/24: 20:30 (signed)

Clinical Pharmacist Medway Heart Institute

DRUG NAME T ATORVA

Dose	Route	Frequency
40mg	oral	0-0-1

Dr. Sign & Reg. No. / Seal: RB 183873
Start Date & Time: 2/1/24 @ 13:00
Stop Date & Time:
Additional Info:

Time 20:00 — 2/1/24: (signed) 0024; 3/1/24: 20:31 (signed)

Clinical Pharmacist Medway Heart Institute

DRUG NAME T. MET XL

Dose	Route	Frequency
25mg	oral	1-0-1

Dr. Sign & Reg. No. / Seal: RB 183873
Start Date & Time: 2/1/24 @ 13:00
Stop Date & Time:
Additional Info:

Time 8:00 — 2/1/24: → ; 3/1/24: [illegible]; 4/1/24: 8:45 (signed)
Time 20:00 — 2/1/24: (signed) 0024; 3/1/24: 20:32 (signed)

Clinical Pharmacist Medway Heart Institute

DRUG NAME T PLAVEDOW - ME

Dose	Route	Frequency
35mg	oral	1-0-1

Dr. Sign & Reg. No. / Seal: (signed) 92469
Start Date & Time: 2/1/24 @ 13:00
Stop Date & Time:
Additional Info:

Time 8:00 — 2/1/24: → ; 3/1/24: 8:30 (signed); 4/1/24: 8:47 (signed)
Time 20:00 — 2/1/24: (signed) 0024; 3/1/24: 20:33 (signed)

Area In-charge Nurse Signature: (signed) 0002 | (signed) 0002 | (signed)

REGULAR PRESCRIPTIONS
To be filled in by Doctors only

DRUG NAME T- NITROCONTIN.

Dose	Route	Frequency
2.6	Oral.	1-0-1

Dr. Sign & Reg. No. / Seal: RD / 183073.

Start Date & Time: 2/1/24 @13:00

Stop Date & Time:

Additional Info:

DRUG NAME TAB. PAN

Dose	Route	Frequency
40 mg	Oral.	1-0-1 (BD)

Dr. Sign & Reg. No. / Seal: RD / 183073

Start Date & Time: 2/1/24 @13:00

Stop Date & Time:

Additional Info:

DRUG NAME T- ALPRAX.

Dose	Route	Frequency
0.5mg.	Oral	0-0-1

Dr. Sign & Reg. No. / Seal: RD / 183073

Start Date & Time: 2/1/24 @13:00

Stop Date & Time:

Additional Info:

DRUG NAME T-ASPN

Dose	Route	Frequency
75mg	S/L	SOS

Dr. Sign & Reg. No. / Seal: RD / 183073

Start Date & Time: 2/1/24 @13:00

Stop Date & Time:

Additional Info:

DRUG NAME

Dose	Route	Frequency

Dr. Sign & Reg. No. / Seal:

Start Date & Time:

Stop Date & Time:

Additional Info:

Area In-charge Nurse Signature:

Date →	To be filled by Nursing Staff only. Sign and time given							
Time ↓	2/1/24	3/1/24	4/1/24					
8:00	→	8:30	8:40					
16:00	→	16:00	16:00					
17:00	→	17:00	17:00					
19:00	19:00	19:00						
21:00	21:00	21:00						
	Jaya	Jaya	Jaya					

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
2/1/24	14:35	IVFNS	500mL	30mL/hr	IV	0.9%	-	-	[illegible]	97241	14.35		[illegible]

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

Date	Time	Intravenous Fluid	Volume	Rate / Duration	Additive Drug				Doctor		Administration		
					Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.

DIET ORDERS *(to be prescribed by Doctors only)*

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
2/1/24	17:00	Normal diet.		91461					
3/1/24	8:00	Normal diet.		91310					
4/1/24	8:00	Normal diet		134559					

NURSE IDENTIFICATION RECORD

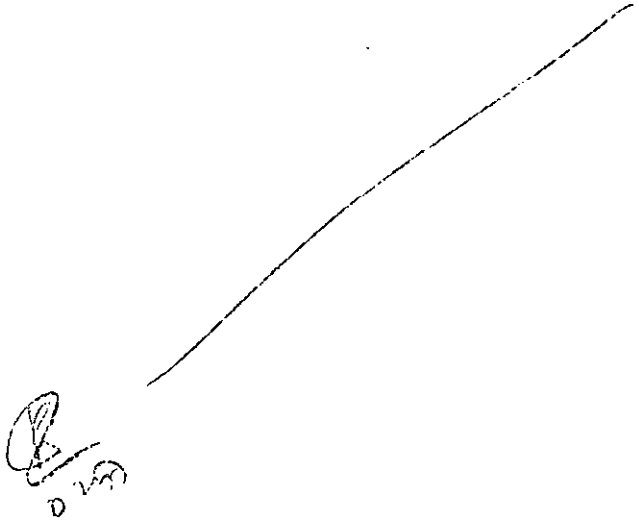
(to be entered by all the nurses involved in administering medications prescribed in the chart)

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
2/1/24	Evening	Ramya. S	0257			Evening			
2/1/24	Night	Rathiga	0240			Night			
3/1/24	Morning	S. Puvanalatha	0211			Morning			
3/1/24	Evening	M. Devika	0182			Evening			
3/1/24	Night	B. Vanisri	0195			Night			
4/1/23	Morning	Pavithra	0072			Morning			
4/1/23	Evening	Jeripriya.	0284			Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

Medline return

CCL
21/4/24

1) T. Ecosprin 150mg → 1/stop.



CCU 2/1/23

1) T. Elospibun 75 mg. → (5)

2) Dosiflow → (1)

MHI/PHARM/2022/060

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REQUISITION FO

Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

Name of Patient :
Age / Sex :
Consultant Name :

IP No. :
DOA : CW
UHID No. :
Room No. :

S.No.	Date	Medicine Name	Qty.
1	2/1/24	T. Asp 150 mg	5
2	"	T. Atorvastatin	
3	"	T. Aldactone 25mg	5
4	"	T. Met XL 25mg	5
5	"	T. Furosemide 80 mg	5
6	"	T. Pan 40mg	5
7	"	T. Clopidogrel 75mg.	5
8	"	Levipod	2
9	"	Inj.	1 amp.
10	"	Syringe 1ml, 5 ml	Each 5
11.	"	Bed wipes	1

Nurse Name

Pharm Bill & Name

Δ Sis: CAD - AWMI - LyseD c̄ CTK C12/23 / MODERA

MHI/ICU/2022/064

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH20240000011
Dr.G. GNANAVELU

[INTE]RMEDIATE CARE FLOWCHART

A

NAME : UHID NO : 202381395 AGE : 48y SEX : M

SURGICA[L PROCEDURE] :

POSTOP DAY : 1 FLUID REQUIREMENT : –

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	CHEST DRAINAGE AIR LEAK	CHEST DRAINAGE H.T.	CHEST DRAINAGE G.T.	TOTAL OUTPUT	I.V. FLUIDS	I.V. FLUIDS	I.V. FLUIDS	I.V. FLUIDS H.T.	ORAL/ R.T. H.T.	ORAL/ R.T. G.T.	TOTAL INTEKE	TOTAL BALANCE
8:00	600	600					600					200	200	200	-400
9:00	–	600					600					–	200	200	400
10:00	–	600					600					50	250	250	-350

SPECIFIC OBSERVATIONS/REMARKS	MEDICATION / DRUGS
–	–

Dis c CAD - Awmi - lysed c̄ STK (12/23) / modu

MHI/ICU/2022/064

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

MEDIATE CARE FLOWCHART

A

NAME : Mr.GOPINATH R   UHID NO : 202381395   AGE : 48y   SEX : M

SURGICAL PROCEDURE : PTCA to LAD & major diagonal + IVUS guided.

POSTOP DAY : D1   FLUID REQUIREMENT : –

DATE & TIME	URINE H.T.	URINE G.T.	CHEST DRAINAGE	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT 700	I.V. FLUIDS IVF NS			H.T.	ORAL/ R.T. H.T.	G.T.	TOTAL INTEKE 200	TOTAL BALANCE
2/1/24 17:00	–	–				+	700	30			30	100	100	330	370
18:00	–	–					700	30			30	–	100	360	340
19:00	–	–					700	30			30	50	150	440	260
20:00	400	1100					1100	30				200	350	670	430
21:00	–	1100					1100	30				–	350	700	400
22:00	–	1100					1100	30				–	350	730	370
23:00	–	1100					1100	30				–	350	760	340
24:00	–	1100					1100	30				–	350	790	310
1:00	–	1100					1100	30				–	300	820	280
2:00	–	1100					1100	30				–	350	850	250
3:00	–	1100					1100	30				–	350	880	220
4:00	300	1400					1400	30				–	350	910	490
5:00	–	1400					1400	30				–	350	940	460
6:00	–	1400					1400	30				–	350	970	430
7:00	–	1400					1400	30				–	300	1000	400

SPECIFIC OBSERVATIONS/REMARKS

–

MEDICATION / DRUGS

–

TE . LV DYSFUNCTION | EF - 38%

MHI/ICU/2022/064

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011

RMEDIATE CARE FLOWCHART

B

NAME : Dr.G. GNANAVELU UHID NO : 202381395 AGE : 48y SEX : M

BLOOD GROUP :

HEIGHT : 168 cm WEIGHT : 61.6 kg B.S.A : 1.75 m^2

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
8:00	60	Sinus	98F	109/66	80	warm	++	15	Br/cl	96%	Pt on Room AIR
9:00	62	Sinus	98°	108/68	80	warm	++	20	Br/cc	95%	"
10:00	57	? Sinus	98F	114/70	88	warm	++	15	Br/cl	96%	"

PREVIOUS DAY - HOURS = 24 hrs

DRAINAGE —

URINE — 1400

TOTAL INTAKE = 1000

TOTAL OUTPUT = 1400

BALANCE = 400 -

ate . LV dysfunction / EF - 38% by

MHI/ICU/2022/064

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Mr.GOPINATH R
48/Male/MHI202381395
02/01/2024/IPH2024000011
Dr.G. GNANAVELU

RMEDIATE CARE FLOWCHART

B

NAME : UHID NO : 202381395 AGE : 48y SEX : M

BLOOD GROUP : O positive.

HEIGHT : 168 cm WEIGHT : 61.6 Kg. B.S.A : 1.75 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
2/1/24 17:00	59	SRM	98.6	110/74	86	Warm	++	16	BRCL	99%	On Room air
18:00	55	SRM	97.4	120/76	90	Warm	++	17	BRCL	98%	"
19:00	53	SRM	97.4	119/79	88	Warm	++	15	BRCL	97%	"
20:00	57	SRM	98.6	119/78	92	Warm	++	16	BRCL	96%	"
21:00	56	SRM	98.6	120/78	89	Warm	++	17	BRCL	95	"
22:00	55	SRM	98.6	120/78	89	Warm	++	14	BRCL	96%	"
23:00	53	SRM	98.6	119/77	91	Warm	++	14	BRCL	96%	"
24:00	50	SRM	98.6	112/68	83	Warm	++	16	BRCL	96%	"
1:00	52	SRM	98	91/55	67	Warm	++	17	BRCL	95%	"
2:00	52	SRM	98.6	87/63	74	Warm	++	18	BRCL	96%	"
3:00	60	SRM	98	87/53	64	Warm	++	17	BRCL	97%	"
4:00	63	SRM	98.1	83/58	70	Warm	++	17	BRCL	98%	"
5:00	50	SRM	96.4	106/69	81	Warm	++	16	BRCL	97%	"
6:00	56	SRM	98.6	103/65	78	Warm	++	12	BRCL	95%	"
7:00	53	SRM	98.6	104/67	79	Warm	++	16	BRCL	95%	"

PREVIOUS DAY - HOURS

DRAINAGE

URINE

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

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MH/ PRINT / 0075 / MRD

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	✓	
- Name, Age & Sex of Patient	✓	
- General Admission Consent	✓	
- Initial Assessment of Patient / Diagnosis	✓	
- Nutritional Assessment by Consultant	✓	
- Plan of care counter signed by the Consultant	✓	
- Treatment Orders - Date, Time, Name & Sign.	✓	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	✓	
- Vital Signs Chart (TPR Chart)	✓	
- Intake Output Chart	✓	
- Drug Chart (Duly filled)	✓	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist		
- Anesthesia Assessment Sheet		
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon		
- Surgery Notes - Post Operative Plan		
- Pain Scoring System		
- Blood Transfusion if done		
- High Risk Procedures		
- A copy of the Discharge Summary	✓	

MHI/IPD/2022/002

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Patient Name: Mr.GOPINATH R
UHID: 48/Male/MHI202381395
DOB: 20/12/2023/IPH202302554
Dr.G. GNANAVELU

ADMISSION SLIP

Medway Heart Institute
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Admitting Doctor: Dr. Gnanavelu **Speciality:** Cardiologist

Advised Date & Time: 20/12/23 @ 10.21AM

Provisional Diagnosis:

ACS - AWMI

Reason for Admission: ☐ Medical Management ☐ Surgical Management
☐ Others (please specify details) CAG

Admission Type: ☐ Day Care ☐ ER ☐ Ward
☐ ICU _____ (Specify details)

Surgery / Procedure Name (if planned):

CAG

Blood Product Requirement: ☐ No ☐ Yes *(Kindly specify details of components required in space below)*

Expected Duration of Stay: Day Care

Expected Cost of Treatment *(as per Financial Counseling Form):*

Payer: ☐ Self ☐ Insurance ☐ Others: CGHS ESI

Instructions to Nurse (if any):

Admission in Re

Any other Instructions (if any):

CSI

Doctor's Signature	Name	Reg. No	Date	Time
	Dr. G. Gnanavelu MD, DM (cardio), FACC Chief Cardiologist Reg. No: 39469		20/12/23	10.20AM

For admission desk staff only:

Room Category:
- ☐ General Ward
- ☐ Single Room
- ☐ Twin Sharing
- ☐ Deluxe Room
- ☐ Suite Room
- ☐ Others R C

Admission intimation Receipt Details		Admission Time in HIS	
Date	Time	Date	Time
20/12/23	10:51AM	20/12/23	10:51AM

Source:
- ☐ OPD
- ☐ ER
- ☐ Direct

To be filled only if Blood requirement specified by the Doctor:

Is Blood Reservation and Blood Bank clearance completed as advised: ☐ Yes ☐ No

Front office Staff Signature	Name	Emp. No.	Date	Time
	Soundarya	2209	20/12/23	10:51AM

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Patient Deta: Mr.GOPINATH R
Name: 48/Male/MHI202381395
UHID: 20/12/2023/IPH202302554
DOB:
DOA: Dr.G. GNANAVELU
Consultant:

MHI/HOSP/2022/129

Medway Heart Institute
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ADMISSION FORM

Marital Status	Full Address	Telephone Number
M	R. Gopinath 28c Govindaswamy St Nanganallur CH-114	+919380597138
Occupation		+8072464859

Referred from	Date of Time of Admission	Date & Time of Discharge	Total No. of Days
DR Gnanavelu	20/12/23@10:58 AM	20/12/23 at 18:30	1hr 30min

UNIT	MLC	If Yes AR No. :
RL	☐ Yes ☑ No	

FINAL DIAGNOSIS	ICD Code
CAD - AWMI - LYSED WITH STC (12/2023)	I25.1
MODERATE LV DYSFUNCTION	I50.1

DATE	OPERATION / PROCEDURES	ICPM Code
20/12/23	CORONARY ANGIOGRAM	88.50

DATE	TYPE OF ANESTHESIA				
20/12/23	☐ GENERAL	☐ SPINAL	☑ LOCAL	☐ REGIONAL	☐ EPIDURAL

DISCHARGE STATUS

☐ Cured	☐ Discharge at Request	☐ Expired < 48 hours
☑ Improved	☐ Against Medical Advice	☐ Expired > 48 hours
☐ Unchanged	☐ Absconded	☐ Post-Operative Death
	☐ Transferred to	

Dr Gny 97211

Signature of the Consultant

Signature of Medical Records Officer

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient....R. Gopinath who is my .....husband..... (Relationship).

I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.

However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.

I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

I have read out and explained the contents of the above to the Signatory in his vernacular .

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி .....;..... .....க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கிறேன்.

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.

நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்	தேதி 20.12.23	G. Selvi G. SELVI
Signature of Admitting Nurse	Date	எனது/உறவினர்/காப்பாளர் கையொப்பம் Signature of the Patient / Relative / Gurdian

9380597138

wife

உறவுமுறை

Nature of Relationship

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Patient Deta
Name: Mr.GOPINATH R
UHID: 48/Male/MHI202381395
DOB: 20/12/2023/IPH202302554
DOA: Dr.G. GNANAVELU
Consultant:

II/IP/2022/008

Medway Heart Institute
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GENERAL CONSENT FOR ADMISSION

I, R. Gopinath the ☐ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

☐ Been explained this consent form in English, which I fully understand.

- I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
- I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
- I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
- I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
- I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.
- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities.
- I have been made aware of the rules and regulations of the hospital including those related to security and I promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of discharge.

- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.

- I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient	R. Gokul	R. Gopinath G. Selvi	20/12/23	10:51 AM
Surrogate/Guardian (if applicable #)	G. Selvi	G. SELVI *(Write name and relationship with patient)*	20/12/23	10:51 AM
Reason for surrogate consent	**Patient is unable to give consent because:**			
Witness	R. Gokul	G. Selvi	20/12/23	10:51 AM
Interpreter (if applicable)	G. Selvi			

** Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent*

DAY CARE DISCHARGE SUMMARY

IP No.	IPH202302554	**D.O.A**	: 20/12/2023
UHID	MHI202381395	**D.O.P**	: 20/12/2023
Name	Mr. GOPINATH. R	**Room No.**	: RL
Age / Gender	48Years /MALE		
Consultant	: **Dr. G. Gnanavelu.** MD., DM., (cardio) FACC Chief Cardiologist	**D.O.D**	: 20/12/2023

DIAGNOSIS:

CAD-AWMI-LYSED WITH STK (12/2023)
MODERATE LV DYSFUNCTION

PROCEDURE: CORONARY ANGIOGRAM DONE ON 20.12.2023 – SIGNIFICANT LAD & DIAGONAL BIFURCATION DISEASE.

BRIEF HISTORY:

Mr. Gopinath. R, 48years old male, presented with complaints of central chest pain associated with sweating (+). He was evaluated in ESIC hospital and advised Coronary angiogram and referred to Medway Heart Institute on 20.12.2023 for which he has been admitted.

ON EXAMINATION:

HR: 78bpm ; BP: 105/64mmHg ; SPO_2 : 99% in room air
CVS: S1S2+ murmur+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD: Hb- 14.5gm/dl, TWBC – 11760cells /cumm, PLT – 213000cells/cumm, Urea – 18mg/dl, Creatinine – 0.7mg/dl, Sodium – 136mg/dl, Potassium – 4.2 mg/dl, Trop I – 23.4, INR – 1.0.

ECG: sinus rhythm, HR – 63bpm, ST elevation in I, VL,V2-V6 leads.

ECHO: RWMA (+) Mid septal, mid anteroseptal hypokinesia. Distal septal, distal lateral apical hypokinesia. Dilated LA, LV. Moderate LV dysfunction EF – 38%. ¼ MR. No PHT / clot/ PE.

CORONARY ANGIOGRAM FINDINGS:

Right-dominant system **SIGNIFICANT LAD & DIAGONAL BIFURCATION DISEASE.**

. (reports enclosed)

ADVICE : IVUS guided PTCA to LAD (2 stents).

ADVICE MEDICATIONS:

SI. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	**TAB. ASA** (ASPIRIN)	150 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	**TAB. AXCER** (TICAGRELOR)	90MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	**TAB. ATORVA** (ATORVASTATIN)	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	**TAB. MET XL** (METOPROLOL)	25 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5	**TAB. ENVAS** (ENALAPRIL)	2.5MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	**TAB. FLAVEDON MR** (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7	**TAB. NITROCONTIN** (NITROGLYCERIN)	2.6 MG	1	0	1	ORAL	ORAL	AFTER FOOD
8	**TAB. PAN** (PANTOPRAZOLE)	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
9	**TAB. ALPRAX** (ALPRAZOLAM)	0.5 MG	0	0	1	ORAL	ORAL	AFTER FOOD
10	**TAB. ISDN**	5 MG	S	O	S	S/C	IF CHEST PAIN	
11	**SYP. CREMAFFIN**	10 ML	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH **DR. G. GNANAVELU FOR PCI AFTER APPROVAL FROM ESIC HOSPITAL on 28.12.2023.**

To report: If temp > 101 'F / Difficulty in breathing / chest pain / Giddiness/ palpitations.
In case of emergency Contact: Medway Hospitals @ 4310 8959.

Dr. G. Gnanavelu MD, DM (cardio), FACC
Chief Cardiologist
Reg. No: 39469

Dr. G. Gnanavelu. MD., DM., (cardio) FACC
Chief Cardiologist

"I understood the Content of the discharge summary."

MHI/NUR/2022/203

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Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

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DAY CARE INITIAL ASSESSMENT FORM

Date: 20/12/23 Time of arrival: 10:54

Part A *(to be filled by Nurses)*

Vital Signs: Temp: 98 (°F) | Pulse / HR: 98 (beats/min) | BP: 185/64 (mmHg)
Respiration: 22 (breaths/min) | SpO_2: 99 (%) | Height: 169 (cms) | Weight: 66 (kgs) | BMI: 23.1 Kg/m²

Any Language Barrier: ☐ Yes ☑ No If yes, please call Language Coordinator / Translator
Allergies : ☐ Yes ☑ No *If Yes, specify* : —

Psychosocial Assessment:
Alcohol Intake: ☐ Yes ☑ No **Substance Abuse:** ☐ Yes ☑ No **Smoking:** ☐ Yes ☑ No
Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☑ No
If Yes, specify details: —

Pain Screening
Pain: ☐ Yes ☑ No. If Yes, Score: 0/10
Pain Scale used: ☐ PIPPS (28 weeks to < 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (Age more than 12 years)
Duration: — Location: —
Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:
Last 3 months Appetite ☐ Increased ☐ Decreased ☑ No Change
Last 3 months Weight ☐ Increased ☐ Decreased ☑ No Change

Fall Risk Screening for adults: ☑ No Risk
☐ Age more than 65 years ☐ History of fall in last 3 months
☐ Walks with assistance ☐ Any neurological problem
In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

Fall Risk Screening *(for pediatrics)*
☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged Mobility ☑ No Risk
In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol

	Signature	Name	Emp. No.	Date	Time
Nurse	[signature]	Aarthi	0282	20/12/23	11:00

Part B *(to be filled by Physicians)*

Chief Complaints

c/o of chest pain associated with sweating.
Evaluated in CTL

Past Medical History

—

Personal History

—

Significant Family History

Current Medication

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1	TAB. ASA	150MG	P/O	0-1-0	19/12/23 at 2pm	☑ Yes ☐ No
2	TAB ATORVA	40MG	P/O	0-0-1	19/12/23 at 8pm	☑ Yes ☐ No
3	TAB. METXL	25MG	P/O	1-0-1	20/12/23 at pm	☑ Yes ☐ No
4	TAB. ENVAS	2.5MG	P/O	1-0-1	20/12/23 at pm	☑ Yes ☐ No
5	TAB. PLAVEDON MR	35MG	P/O	1-0-1	20/12/23 at pm	☑ Yes ☐ No
6	TAB. NITROCONTIN	2.6MG	P/O	1-0-1	20/12/23 at pm	☑ Yes ☐ No
7	TAB. PAN	40MG	P/O	1-0-1	20/12/23 at 8am	☑ Yes ☐ No
8	TAB. ACPRAM	0.5MG	P/O	0-0-1	19/12/23 at 8pm	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

CBG - 79mg/dl.

Clinical Examination / Investigation

CVS :- S1 S2 ✓
RS - NVBS.
Abdomen - Soft

Hb - 14.5
creat - 0.7
Urea - 18
Serology - Negative.

Provisional Diagnosis

CAD - AWMI - LYSED WITH STLC (12/2023)

MODERATE LV DYSFUNCTION

Plan of Care (including Investigations Ordered)

CAG

Doctor's Signature	Name Dr. Sudhan	Reg. No. 57 LL	Date 20/12/23	Time 11.00

MHI/IP/2022/041

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Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

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DOCTOR'S PROGRESS NOTES

DATE	NOTES
20/12/23 1:30pm	CAG
	- Rt radial access
	- 5F sheath.
	- 5F TIG → CAG done
	Imp: Rt dominant / significant LAD & Diagonal bifurcation disease
	Adv: IVUS guided PTCA to LAD (2 stents).
	[signature]
15-00	pt received.
	Stable.
	Alo oozing & haematoma.
	CAG :- Rt dominant, significant LAD & Diagonal Bifurcation disease.
	Rx :- IVUS Guided PTCA to LAD (2 stents) later.
	[signature]
16.00	pt can be discharged.
	[signature]

MHI/DIET/2022/147

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Patient Details *(Affix Label here)*
Name: Mr. Gopinath-R
UHID: MH/2023/3945
DOB: 49 years Sex: Male
DOA: 20/12/23
Consultant: Dr. A. Saravelu

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: CAG/ CAD – AWMI WITH STK (2023) EF-38%				
Height: 169 cms	Weight: 66 Kgs	Food allergies: Yes/ No If yes, specify.....		
Religious Beliefs:	☐ Vegetarian	☑ Non Vegetarian	☐ Eggetarian	☐ Jain
Diet Prescription: 1800 calories, low fat, low salt diet (2000ml fluid restricted)				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

	(A)	Patient's related Medical History				
	1)	Weight Change (overall change in past 6 months)				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No weight change/ gain	<5%	5 - 10%	10 - 15%	>15%
2)	Dietary Intake	Duration:				
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Oral	No change	Sub - optimal solid diet	Full liquid diet/ moderate overall decrease	Hypo - caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo - caloric feeds	Starvation
3)	GastroIntestinal Symptoms Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anoreda
4)	Functional Capacity (Nutrition related functional impairment) Duration:					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		None /Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5)	Co - morbidity (Disease and its relationship to nutrition requirements)					
		☐ 1	☐ 2	☑ 3	☐ 4	☐ 5
		Healthy	Mild co - morbidity	Moderate co - morbidity/ age >75 years	severe co - morbidity	Very severe multiple co - morbidity
6)	Physical examination					
1)	Decreased fat stores or loss of subcutaneous fat					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
2)	Sign of muscle wasting					
		☑ 1	☐ 2	☐ 3	☐ 4	☐ 5
		Normal	Mild	Moderate		Severe
Total Score = Sum f above 7 components						
Nutritional Status : Based on this patient is						
	Well Nourished		☑ (7 to 14) 9			
	Moderately Malnourished		☐ (15 to 18)			
	Severely Malnourished		☐ (19 to 35)			
Nutrition Intervention:						
	☑ Oral		☐ Enteral		☐ Parenteral	
Diet counselling provided:	☑ Yes		☐ No			
Frequency of re-assessment:	☑ Weekly			☐ Fort - night		☐ Monthly
Enteral / Parenteral	☐ Daily			Calorie count:	☐ Yes	☑ No

Dietitian Signature / Name / Date / Time: Senior Dietitian 20/12/23 16:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
20/12/23 16:00	A 48 years old male came c/o central chest pain, sweating was assessed to be well-nourished as evident by SGA. NO-Eo-Morbidity patient shifted to cathlab for procedure (CAG). kept on NBM. patient received to Radial lounge. NBM over, patient started liquid diet can initate & Soft solid diet Educated the patient and family on 1800 calories, low Fat, low salt diet on discharge. (2000ml fluid restricted) emphasized the small frequent meals, diet modifications and clarifications done. Diet chart given discharge	Dr. Catherine John Dietitian Dr. Catherine John Senior Dietitian

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Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

MHI/NUR/2022/111

Medway Heart Institute
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PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD/AWMI/MODLVD/DYSED STK Allergies if any: NIL

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
RL	cathlab	20/12/23	13.00	CAG.

Method of Transfer: ☐ On Bed ☑ On Wheelchair ☐ On Stretcher

ASSESSMENT OF PATIENT:
General condition of Patient: ☑ Conscious ☐ Semi-conscious ☐ Un-conscious

Language Barrier: ☐ Yes ☑ No ☐ If Yes, specify: _____

Fall Risk Category: ☑ Low Risk ☐ Medium Risk ☐ High Risk

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.2°F	20	78.	99%	105/64	0/10.

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

	Signature	Name	Emp. No.	Date	Time
Handover by		Aarthi	0282	20/12/23	13.00
Handed over to		V. Abinaya	0220	20/12/23	13.00

After Procedure:
Procedure completed: ☐ Yes ☑ Yes | Any critical information: NIL

Vital Signs *(to be documented at the time of shifting)*:

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO_2 (%)	BP (mmHg)	Pain Score
98.6	22 b/m/s	57 b/m/s	100%	92/54/68	4/10

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☑ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

	Signature	Name	Emp. No.	Date	Time
Handover by		V. Abinaya	0220	20/12/23	14.25
Handed over to		Aarthi	0282	20/12/23	14.25

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Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

Dr Gnanavelu has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with bleed. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(i)The nature of coronary artery disease (ii)The pumping status of the heart (iii) Your age and general health

These are some of the more serious risks that can happen, but are not the only risks:

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death
1 in 100 people (0.01%)	(I)the heart may not beat in a proper rhythm which will need urgent treatment (j) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin punture site
Most People	(n) Minor bruising

PATIENT CONSENT:

P acknowledge that Dr Gnanavelu has explained my medical condition and the proposed procedure. I understand the risks of the procedure, the anaesthetic including the risks that are specific to me and the likely outcomes if complications occur. The Doctor has explained other relevant treatment options their risks and my right to refuse the treatment . He has explained my prognosis and the risks of not having the procedure. I have been explained that some reprocessed items might be used once its sterility and integrity is confirmed. I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and converns have been discussed and answered to my satisfaction. I understand that in the unlikely event of complications, I may require a blood transfusion, an additional procedure or surgery. The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that no guarantee has been made that the procedure will improve the condition.

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		MR. GOPINATH.	20/12/23	11:00
witness	G	MRS. SELVI (WIFE)	20/12/23	11:00
Doctor		Dr. Balaji Sudhan	20/12/23	11:00
Interpreter				

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Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் ..... அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியகோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளள காண்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த காண்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிட்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிட்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (பலூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம்

ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் இவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I)இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) காண்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் ..... அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையினுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிசெய்யப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில், எனக்கு இரத்தமேற்றுதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்டும் என்பதை எனக்கு விளக்கினார், இச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்திரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழிபெயர்ப்பாளர்				

JCI ACCREDITED NABH ACCREDITED

MRD

Medway Heart Institute

Every heart beat counts

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TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	**Mr. GOPINATH.R**	**ID:**	**MHI202381395**
Age/Gender :	**48 M**	**IPH:**	**IPH202302554**
Cath No. :	**3435**	**DOP:**	**20.12.2023**

Done by	Assisted by	Technician
Dr.Gnanavelu/Dr.Salaisudhan	Ms. Abinaya	Mr. Ram

DIAGNOSIS: CAD; AWMI-LYSED STK(12/2023); MODERATE LV DYSFUNCTION

Access: Right Radial artery — Total exposure time: 3'58"

Hardware used: 5F sheath, 5F TIG — DAP : 10.5 Gy.cm2

Contrast used: CONTRAPAQUE 40 ml — Total RAK: 108 mGy

Medications given: Inj NTG 200 mcg & Inj Heparin 2500 IU IA

Hemodynamic data: Ao Pressure – 90/50(63) mmHg, HR – 76/min, Spo2 – 99%

Selective coronary angiogram done in multiple angulated views :

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCX
LAD	Type 3 vessel. Proximal LAD shows luminal irregularities. Mid LAD astride first diagonal shows 90% tubular stenosis. Distal LAD after third diagonal shows 70% tubular stenosis. Gives 3 diagonals. First diagonal is a major vessel, ostioproximal part shows 70% tubular stenosis. Second diagonal shows diffuse disease. Third diagonal shows luminal irregularities.
LCx	Non Dominant. Proximal LCX shows luminal irregularities. Distal LCX is a thin vessel with luminal irregularities. Gives 3 OMs. OM1 is an early and major vessel, shows luminal irregularities.
RCA	Dominant. Proximal RCA appears normal. Mid RCA shows 20% discrete stenosis. Distal RCA appears normal. PDA and PLv appear normal.

FINDINGS: RIGHT DOMINANT; SIGNIFICANT LAD & DIAGONAL BIFURCATION DISEASE

ADVICE: IVUS GUIDED PTCA TO LAD (2 STENTS)

Dr. G. GNANAVELU, MD, DM

G. Salai

Dr. G. Gnanavelu MD, DM (cardio), FACC
Chief Cardiologist
Reg. No: 39469

Medway Heart Institute
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Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

/2022/048

DATE & TIME	Observation / Action	Signature with Emp.No
20/12/23 @ 11.00	Patient Received from RL patient is conscious & oriented pt vitals are monitoring. Skin preparation done. CATH LAB	
20/12/23 12.50	⇒ patient received RL to cath lab pt conscious & oriented pt vital stable	
13.20	⇒ CAG procedure started Rt Radial artery approach.	
13.26	⇒ INJ: NTG 200mcg + INJ: Heparin 3500 IV given O/B DR GNS	
13.25	⇒ HR: 57 bpm BP: 90/52 (69) mm/Hg SpO2 100% vital stable	
13.30	⇒ CAG procedure done Rt Radial artery sheath removed tight pressure bandage no active no oozing no chemosis	
14.25 14.35	⇒ pt shifted cath lab to RL pt Received from cathlab. CAG done, Rt Radial approach.	
14.50	pt take liquid there is no any issues.	

Document endorsed by	Signature	Name	Emp. No.	Date	Time
		Sathy	0016	20/12/23	13.30

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MHI/NUR/2022/048

DATE & TIME	Observation / Action	Signature with Emp.No
14.50	Pt Received from RL, GAG done. Rt Radial approach, Pt is Conscious & Oriented, pt vitals are monitoring.	A 0282
15.00	pt take oral liquid there is no Pain & voided.	A 0282
15.30	pt take oral diet.	
16.00	pt on continous cardiac monitoring there is no any abnormality.	A 0282
17.00	puncture side there is no hematoma, bleeding	A 0282
18.15	pt discharged, pt d/c Summary CAG CD & Report given to pt attender.	A 0282

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jay	JAYADEVI J	0002	20/12/22	18.30

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NABH

Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

MHI/NUR/2022/045

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BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

					Date: 20	12	23
					Time: M	E	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain oyer most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slight Limited** Makes frequent through slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance	4	4	
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NPO and / or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3	
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	
				TOTAL SCORE	19	19	
				Initial & Emp. No. of Staff Nurse:	ABN 5281	ABN 5281	
				Initial & Emp. No. of Sr. Staff Nurse:			

Score Interpretation: *Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6*

S.No. : 22

MHI/CATH/2022/085

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Medway Heart Institute
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Procedure Monitoring Sheet (Cath Lab)

Patient Name :	Mr.GOPINATH R 48/Male/MHI202381395	Age / Sex :	
UHID / IP :	20/12/2023/IPH202302554	Ward Unit :	
Consultant :	Dr.G. GNANAVELU	Diagnosis :	

Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse)

PARAMETERS	YES	NO	NA
Vital signs : BP: 105/64 Temp: 98.2 Pulse: 78 RR: 20 SPO2: 99%	✓		
Urine voided	✓		
Bowel preparation		✓	
Pre-procedure medication administered		✓	
Procedure site marked	✓		
Skin preparation done	✓		
NPO : 7.00 am			
Loose Tooth removed		✓	
Contact lenses / Eye glasses removed		✓	
Prosthesis present		✓	
Jewellery/Nail polish removed	✓		
Checked for Allergies (Drug / food)	✓		
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse :	Date & Time : 20-12-23 @ 11.00		

Intra – Procedural Record (To be filled by the Cath Lab Nurse)

Time	HR / min	RR / min	BP mmHg.	SpO2%	Medication / Remarks	Sign. of Nurse
13:20	57 bt/min	22 br/min	94/52(68)	100%	—	
13:25	60 bt/min	22 br/min	92/54(96)	100%	—	
	procedure got over					

Post Procedure Follow Up Data (to be filled by the doctor)

Time : 12.35 Route : Rt Radial artery approach

Complication : Nil

BP : 92/54(66) mmHg, HR : 57 bt/min, RR : 22 bt/min, SpO2 : 100 %

Distal Pulse: felt, Puncture Site: no oozing no chemton

Advise:

- Shift To: Ward / ICU
- Bed rest up to 4 hours
- Observe puncture site for bleeding
- Watch for Pulse in Rt Radial artery.
- Diet

- Inform Duty Medical Officer SOS
  a) If patient complains of any Discomfort
  b) If dressing is Loose or Socked with Blood
  c) If limbs are Cold / Absent Pulse
- Remove Rt Radial dressing on 21/12/23 at 12.25 AM /PM after informing to the consultant.
- Special instruction if any:

Nil

Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
21/12/23 12:55	98/56	57	22	100 %	no oozing no chemton	Good	—	
1/4:15	96/67	56	22	100 %	"	"	—	

Nurses Notes :

CAG procedure done Rt. Radial artery sheath removed tight pressure bandage applied no oozing no chemton cath intact

Condition at the end of procedure : ☑ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☐ CCU ☐ Other RR

Name & Signature of the Nurse : Date & Time : 21/12/23 14:25

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NABH ACCREDITED

Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

MHI/NUR/2022/047

Medway Heart Institute
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DVT RISK ASSESSMENT

Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10

	Date	20/12/23						
	Time	11-00						
S. No.	**PARAMETERS**							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0						
2	Bedridden recently >3 days or major surgery within four weeks	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0						
5	*Entire leg swollen (Assess for both legs)*	0						
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0						
9	Previously documented DVT (Assess for both legs)	0						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / *Renal disease, Renal failure, CCF Cellulitis* (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0						
	FINAL SCORE	0						
	Low Risk: -2 to 0 | Moderate Risk: 1 to 2 | High Risk: 3 to 8							
	DVT prophylaxis started	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN							
	Signature & Emp. No. of Sr. RN							

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Mr.GOPINATH R
48/Male/MHI202381395
20/12/2023/IPH202302554
Dr.G. GNANAVELU

MHI/NUR/2022/046

Medway Heart Institute
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MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables										
	Date	20/12/23	20/12/23							
	Time	10.00	14.25							
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		20	20							
Low Risk (0 - 24)		✓	✓							
Medium Risk (25 - 44)										
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

0 - 24: Low Risk; 25 - 44: Medium Risk; 45 or above: High Risk

INTERVENTIONS *Tick as per the Risk Score*	Date	20/12/23	21/12/23						
	Time	11:00	14:25						
Low Risk Interventions (0 - 24)									
Familiarize the patient with the immediate surroundings		✓	✓						
Remind the patient to use call bell before getting out of bed		✓	✓						
Keep the two side rails in the raised position at all times for all patients regardless of age		✓	✓						
Keep the call bell, bedside table, water, glasses within the patient's easy reach		✓	✓						
Remove excess equipment or furniture to make a clear path		✓	✓						
Keep the patient's bed in the low position at all times except during procedure		✓	✓						
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed		✓	✓						
Bed wheels should be locked		✓	✓						
Encourage family participation in the patient's care		✓	✓						
Ensure that floor of the bathroom is dry and not slippery		✓	✓						
Review medications for potential side effects that can promote falls		✓	✓						
Use safety belts during movement in wheelchair		✓	✓						
The patients are not ambulated by themselves. They are to be ambulated only with assistance		✓	✓						
Medium risk interventions (25 - 44)									
Apply all the low risk interventions									
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher									
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat									
Use restraints and bed monitors as ordered by the doctor									
Allow the patient to ambulate only with assistance									
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care									
Do not leave patients unattended in diagnostic or treatment areas									
Accompany the patient while going to bathroom									
Advice the patient to use grab bars near the toilet, bathtub, and shower									
Make sure the family and other visitors understand the restrictions mentioned above									
High-risk interventions (45 or above)									
Apply all the low and medium risk interventions									
Tie red fall risk tag in the bed, wheel chair and stretcher									
Locate the high-risk patients in a room close to the nurses' station									
Answer these patients call bells as quickly as possible									
Provide a commode at bedside (if appropriate)									
Urinal/bedpan should be within easy reach (if appropriate)									
Encourage family members or other visitors to stay with them									
If appropriate, consider using protection devices: safety belts									
Signature & Emp. No. of RN									
Signature & Emp. No. of Sr. RN									

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NABH

Mr.GOPINATH R
48/Male/MHI202381395
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Dr.G. GNANAVELU
Consultant

MHI/NUR/2022/052

Medway Heart Institute
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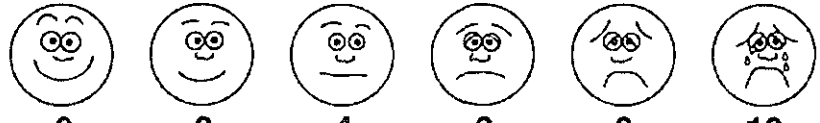
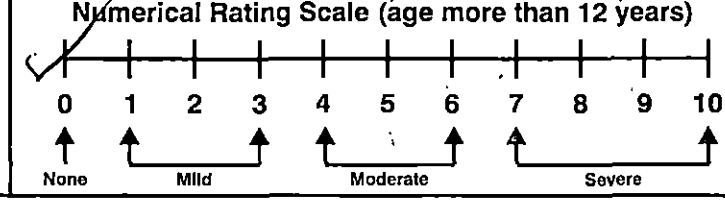
PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
20/12/23 11.00	0/10	No pain	-	-	-	ARM 0282	
		patient- Received from @ 14.25					
14.25	0/10	No pain	-	-	-	ARM 0282	
15.25	0/10	No pain	-	-	-	0282	
16.25	0/10	No pain	-	-	-	0282	
17.25	0/10	No pain	-	-	-	0282	
18.15	0/10	PT Discharged.					

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.

PAIN SCALES

PIPPS (28 weeks to ≤ 38 weeks)	**6 or less** = Minimal to no pain **7 - 12** = Mild pain - Provide comfort measures **>12** = Moderate to severe pain - Pharmocological intervention
CRIES (38 weeks - 2 months)	**The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.**
FLACC Scale (2 months - 7 years)	**0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both**
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	**FACIAL EXPRESSION:** 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing **BODY MOVEMENTS:** 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation **COMPLIANCE WITH VENTILATION (intubated patients):** 0 - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting ventilator (or) **VOCALIZATION (non-intubated patients):** 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing **MUSCLE TENSION:** 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid **TOTAL SCORE:** 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain
Non-pharmacological Interventions	**Distraction:** A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers **Cutaneous Stimulation and massage:** E - Positioning; F - Rubbing / Massage the skin **Thermal Therapies** (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy **Transcutaneous electrical nerve stimulation** (TENS): J - Interferntial therapy | **Psycho-social therapy/counselling:** K - Individual Counseling; L - Family counseling

Pharmacological Interventions as per doctor's prescription

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

', 1st Main Road, United India Colony , Kodambakkam, Chennai, Tamilnadu, In

044-2473 4455

care@medwayhospitals.com

Registration No	: MHI202381395	**Patient Name**	: GOPINATH R
Age	: 48	**Gender**	: Male
IP Number	: MMH/HM/IPH202302554	**Discharge Date**	: 20/12/2023 7:51:00PM
Bill No	: MMH/HM/IPH00556	**Bill Date**	: 20/12/2023 4:45:31PM
Ward Name	: RADIAL LOUNGE	**Bed Name**	: RL-5

NO DUE

Prepared By

Approved By

Checked By